STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the complaint investigation of #35544, 36058, 34447, 35335, 34423 and 36508, conducted on June 3-16, 2015, at Claiborne and Hughes Health Center, deficiencies were cited in relation to the complaints #35544, 36058, and 34423 under 42 CFR PART 483, Requirements for Long Term Care Facilities. Complaints #34447 and 36508 were substantiated with no deficiencies cited. Complaint # 35335 was not substantiated. The facility was cited at a Substandard Quality of Care for the failure to provide adequate staffing to provide residents with the Activities of Daily Living necessary in order to meet the resident's needs.	F 000	Below is the Plan of Correction for the Complaint Survey completed at Claiborne and Hughes Health Center on 6/16/15. Responses do not reflect guilt, but offer facility's solutions to areas identified by the Survey Team. F157 The facility will immediately inform the resident, consult with the physician and notify the resident's responsible party when there is an accident involving the resident which results in injury and has potential for requiring physician interventions, a significant change in resident's physical status in either life threatening conditions or clinical complications. Corrective Action Nursing personnel reviewed the occurrence report completed on resident #11 and contacted family to assure notification had occurred. Family acknowledge awareness and nursing personnel involved were educated on importance on notifying physician and family for incidents which result in injury and documenting that notification was made. Method of Correction for all Residents Standing orders for skin tears to be reviewed, updated and signed off by Medical Director; and Nurses are to be in-serviced on these standing orders which will be placed in nursing document notebook at each nurses station. All new	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dara P. Oldhamer — TITLE: Administrator — (X6) DATE: 7/8/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview, the facility failed to notify the physician and the resident's legal representative of an incident involving injury for 1 (Resident #11) of 17 reviewed. The findings included: Review of a facility policy Fall Committee Protocol (and includes skin tears), undated, revealed "...family/ Md [Medical Doctor] have been notified..." Medical record review revealed Resident #11 was admitted to the facility on 6/5/14 with diagnoses including Dementia with Behavioral Disturbances, History of Falls, Dysphagia, Muscle Weakness, Depression, Congestive Heart Failure and Diabetes Mellitus. Medical record review of a Quarterly Minimum Data Set dated 3/10/15 revealed Resident #11 was severely cognitively impaired and was total care for Activities of Daily Living.	F 157	F157 continued hire nurses will be educated on nursing document notebook contents during orientation. Nurse Management will review all occurrence reports within 24 hours of occurrence and will check all for proper documentation of incidents including notification of family and physician. New occurrence report form provides for signing off that notification has been done and documented. Occurrence Review committee (ORC) will conduct a second check at weekly meetings where incidents are reviewed. QAPI and monitoring DON or designee will review occurrence reports and the Medical Record of resident involved weekly for compliance. Audit developed will be kept that shows resident name/date of incident/type of incident/is it unknown origin/ family and physician notified/ documentation completed in Medical Record. Any non compliant nurses will be counseled and educated. Monitoring will continue weekly until 90% compliance is maintained and will then be monitored monthly to assure continued compliance. Compliance findings will be brought to the QAPI regular meeting and reviewed along with suggested recommendations or need for further education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 Observation on 6/4/15 at 1:09 PM revealed Resident #11 was seated in a geriatric chair in the hallway outside her room. Continued observation revealed a healing skin tear on the resident's right forearm that was half-moon shaped, red with edema and bruising. Medical record review of Physician's Orders from 5/1/15 to 6/4/15 revealed no orders for treatment of the skin tear to right forearm. Medical record review of a Monthly Nursing Summary dated 6/3/15 revealed no documentation of a skin tear to right forearm. Medical record review of nursing notes from 5/1/15 to 6/4/15 revealed no documentation that the physician or the family were notified of the injury. Interview with Licensed Practical Nurse (LPN) #4 on 6/4/15 at 4:10 PM at the 2nd floor West nurses station, when asked about the resident's skin tear stated, "...there's no order for treatment..." Continued interview, when asked when the injury occurred, LPN #4 stated, "...about a week ago..."	F 157	F157 continued Completion Dates Incident with Resident 11 reviewed and family notified. **06/19/15** Nurses educated on physician and family notification and on skin tear standing orders. **07/10/15** Tool for compliance monitoring developed for utilization **06/29/15**	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224	F224 The facility will develop and implement policies and procedures that prohibit mistreatment, neglect and abuse of residents. Corrective Action All situations involving observations of residents 8/11/15/17 were reviewed to determine staff needing counseling/guidance or training of resident needs and documented education was provided on resident needs and neglect as a form of abuse. Issues of focus were toileting times and assistance needed during toileting. Residents have been identified who are in need of assist in toileting and staff will have available updated list of toileting needs. The list will be updated as needed by MDS nurse. Nursing Administration reviews staffing coverage daily and will assure resident needs are met for toileting throughout the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview, the facility failed to prevent neglect by providing incontinence care for 4 (Resident #8, 11, 15, 17) of 17 residents reviewed. The findings included: Review of the undated facility policy "Abuse Prevention/Reporting..." documented "...Every resident has the right to be free from mistreatment, neglect..." Further review documented "Negligence: Failing to properly care for resident in a manner conducive to professional standards." Review of the facility policy "Resident Call Lights" documented "...It is the policy...for all employees to assist in the answering of call lights in a timely manner..." Further review documented "...Staff to be alerted when the call lights sound...and work to respond within 5-7 minutes whenever possible. If a staff member who responds is not a nursing personnel and the request is nursing related, it is the staff member's responsibility to find a nursing personnel to answer the concern and follow up to assure situation is handled, when possible...Whenever CNT [Certified Nurse Technician/Aide] staff go on break, they must inform their Charge Nurse or another staff member on that hall to assure that their call lights can be answered..." Medical record review revealed Resident #8 was admitted to the facility on 12/12/12 with diagnoses	F 224	F224 continued day by assigning a hall monitor making random checks on residents listed as having toileting needs. Monitor will utilize QAPI audit tool developed and provide findings to Nurse Management after each round. Method of Correction for all residents Nurse Management and selected staff members are reviewing all resident toileting needs to determine how much assistance is needed. Each nurses station will be provided an updated list each month of residents and their level of assistance in toileting. Nursing Administration reviews staffing coverage daily and will assure resident needs are met for toileting throughout the day by assigning a hall monitor making random checks on residents listed as having toileting needs. As issues are found or reported, staff will be counseled and educated on their lack of care and will be asked to provide assurance of care personally to the resident and their family. QAPI and monitoring DON or designee will review ADL documentation on toileting to ensure proper adherence of incontinence care weekly until compliance threshold is reached and then monitoring will be at least monthly to assure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 4 including Aftercare of Right Hip Fracture, Dysphagia, Dementia, Brain Mass, and Aortic Stenosis. Medical record review of a Quarterly Minimum Data Set (MDS) dated 12/14/14 documented Resident #8 was severely cognitively impaired. Continued review revealed the resident was non-ambulatory, was totally dependent for transfers, hygiene, bathing and dressing and was always incontinent of bowel and bladder. Medical record review of the care plan dated 10/2014 and updated 3/21/15 revealed the resident was incontinent of bowel and bladder. Continued review revealed the goal of "Resident will be kept clean and dry thru next review date", and interventions "...provide incontinent care and change briefs as needed..." Further review of the care plan revealed the resident was at risk for skin impairment due to incontinence with a goal of "...keep clean and dry..." and interventions of "...check frequently for episodes of incontinence ..." Observation of Resident #8 on 6/15/15 at 7:40-8:39 AM, revealed the resident was in the 1st floor dining room for breakfast. Further observation at 9:00 AM, revealed the resident was seated in a geriatric chair in the hall across from the 1 West nurses station. Further observation at 10:45 AM, revealed the resident seated in the geriatric chair in the dining room during an activity. Continued observation of the resident revealed she remained in the dining room at 11:50 AM. Further observation revealed the resident was in the dining room until 1:10 PM, at which time she was observed transported to the hall across from the 1 West nurses station.	F 224	F224 continued The monitoring tool use on random audits to view compliance for incontinence care will include resident name, room number, day and time of day, resident orientation, comments from resident and if resident is dry. Audits will be conducted weekly by designee of DON. Compliance will be met when 90% report toileting needs have been addressed. Findings/recommendations will be shared with the QAPI committee for further monitoring. Monitoring will be done by Nurse Management or their designee. Each nurses station will be provided a updated list each month by Nurse Management of residents and their level of assistance in toileting. list of toileting needs. These lists will be used as a part of the audit conducted weekly. Completion Date Resident lists reviewed and updated on toileting needs **7/10/15** Staff educated on abuse/neglect of residents with examples provided **07/14/15** Audit tool developed and utilized **7/7/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 5	F 224		

Further observation at 2:30 PM, revealed the resident was in the dining room for activities. Further observation revealed the resident remained in the dining room at 4:15 PM.

Interview with Certified Nurse Assistant (CNA) #15 on 6/15/15 at 4:45 PM, in the hall outside room 115, revealed she had come on duty at 3:00 PM. CNA #15 stated she had not yet checked Resident #8 for incontinence. Continued interview revealed the resident would remain in the dining room through supper and after that she would sit in the hall until she was ready for bed. Continued interview revealed the resident would be checked for incontinence and changed when she was put to bed. Continued interview revealed the resident had last been checked for incontinence by the staff on the previous shift who had been assigned to the resident's care.

Interview with Licensed Practical Nurse (LPN) #6 on 6/16/15 at 7:20 AM, in the 1 East Hall, revealed he had been assigned to care for Resident #8 on the 7:00 AM to 3:00 PM shift on 6/15/15. Continued interview revealed the resident was checked for incontinence once on the morning of 6/15/15 and at no other time during his shift. Continued interview confirmed the facility neglected to provide incontinence care for the resident.

Interview and observation with CNA #1 on 6/16/15 at 11:18 AM in the resident's room, revealed she was assigned to the resident's care this date. Continued interview revealed the resident was out of bed and seated in a geriatric chair before she came on duty at 7:00 AM. Continued interview revealed the resident had not been checked for incontinence over the past 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 6	F 224		

hours. CNA #1 was then asked to check the resident for incontinence. Observation revealed CNA #1 transferred Resident #8 to the bed. Continued observation revealed the resident's incontinent brief was wet from urine. Interview with CNA #1 confirmed the facility had neglected to provide incontinence care to Resident #8.

Medical record review revealed Resident #11 was admitted to the facility on 6/5/14 with diagnoses including Dementia with Behavioral Disturbances, History of Falls, Dysphagia, Muscle Weakness, Depression, Congestive Heart Failure and Diabetes Mellitus.

Medical record review of the Quarterly MDS dated 3/10/15 documented Resident #11 was severely cognitively impaired, and required total assistance with Activities of Daily Living and was always incontinent of bladder and bowel.

Medical record review of a care plan dated 6/18/14 documented "...at risk for skin to become impaired..." included interventions including "...check frequently for episodes of incontinence..."

Observation of Resident #11 on 6/15/15 at 2:15 PM and at 4:22 PM, revealed resident seated in a geriatric chair, facing the 2nd floor dining room doorway. Continued observation revealed the resident had dried food and stains on her top and pants, and her hair was uncombed.

Observation and interview of Resident #11 on 6/15/15 at 4:39 PM, after surveyor requested CNA #16 to check the resident for incontinence and the resident was taken to her room, revealed the resident's brief was wet with urine and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 7	F 224		

contained a small amount of feces. Continued observation revealed the resident's buttocks and perianal area was red. Interview with CNA #16 stated "...I need to change her clothes...they are dirty..."

Medical record review revealed Resident #15 was admitted to the facility on 6/14/13 with diagnoses including Dementia, Abnormal Posture, Hypertension, Oral Dysphagia, Hallucinations, Anxiety with Depression.

Review of the Annual MDS dated 6/3/15 documented the resident had short and long term memory impairment and required extensive assistance from 1 person for bed mobility and transfers. The resident was always incontinent of bladder and bowel.

Medical record review of the comprehensive care plan dated 6/3/15 documented a problem of "Resident is Incontinent of Bowel and Bladder-Risk for recurrent UTI". The interventions included "...Provide daily care for resident; Provide incontinent care as needed; Turn and reposition while in bed or in chair for comfort and to reduce risk of impaired skin..."

Observation of Resident #15 on 6/3/15 at 12:57 PM in the 1st floor dining room revealed the resident was seated in a reclining Geri-chair and had just finished her lunch. The resident stated, "I have to go to the bathroom." The Activities Director stated, "You'll have to wait until a tech [Certified Nurse Aide] can take you." Further observation revealed the Activities Director asked the Activities Assistant to take the resident to her room. The Activities Assistant was taking another resident out of the dining room and said she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 8	F 224		

would when she returned. The Activities Assistant returned at 1:05 PM and pushed Resident #15 in the Geri-chair out of the dining room into the hallway beside the resident's room and left her sitting there. Continued observation revealed the resident was lying in the recliner with her eyes closed, and stated, "...take it off, it hurts..." No one came to assist the resident. At 1:30 PM CNA #13 was asked by the surveyor to check the resident for incontinence. The resident was moved into the room, placed on the bed, and was found to be incontinent of urine.

Interview with CNA #13 at 1:37 PM in room 110 A confirmed the resident was incontinent of urine and the facility neglected to provide care to Resident #15.

Interview with LPN #12 on 6/11/15 at 3:30 PM in the pharmacy room confirmed the resident had been in her recliner all day (6/11/15), and had not been changed.

Interview with the Director of Nursing (DON) on 6/16/15 at 2:00 PM in the pharmacy room when asked if there was enough facility staff to meet the required care for the residents stated, "I can't say that we've met everyone's needs."

Medical record review revealed Resident #17 was admitted to the facility on 1/31/08 with diagnoses including History of a Cerebral Vascular Accident resulting in Left Sided Hemiplegia, Chronic Cervical Pain, Chronic Obstructive Pulmonary Disease, Diabetes, and Anxiety.

Review of the Quarterly MDS dated 4/12/15 documented the resident was cognitively intact, and required extensive assistance from 1 person

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 9	F 224		

for bed mobility, transfers, dressing, toileting and personal hygiene. The resident was totally dependent for bathing, occasionally incontinent of urine and always continent of bowel.

Interview with Resident #17 on 6/9/15 at 12:55 PM in the 1st floor dining room revealed the resident had not been assisted out of bed, dressed, or toileted until 12:30 PM. The resident confirmed her normal routine was to be up, bathed, and dressed by 7:00 or 7:30 AM. Continued interview revealed the resident had pushed her call light 3 different times and LPN #6 was working as a CNA had answered her call light all 3 times. Continued interview revealed each time the resident had asked for assistance to get up and go to the bathroom, the LPN would say, "I'm passing trays, or I'm picking up trays...we don't have enough staff today...we'll get to you as soon as we can." Continued interview revealed that even after the resident had told the LPN she was now wet, no assistance was provided. Continued interview revealed the resident became incontinent of urine and had to lie in her saturated bed for 5 hours.

Interview with LPN #6 on 6/9/15 at 1:50 PM in the 1 West nurses station confirmed he was the LPN working as a CNA. The LPN stated, "...They need more staff. The residents want to be up by 7:00 AM, and nights are supposed to get them up but there isn't enough staff..." Continued interview confirmed the LPN did answer the call light for Resident #17 on 3 different occasions that day and did not assist her to the bathroom or with incontinence care, bathing and dressing as per the residents' preferences.

Interview with CNA #5 on 6/10/15 at 2:40 PM in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 10 the pharmacy room confirmed Resident #17 was alert and normally continent of urine and stated, "...The only reason she was wet and not up until 12:30 [PM] was cause staff couldn't get to her, cause we're always so short..." Interview with Resident #17 on 6/11/15 at 11:00 AM in the resident's room confirmed she had to lie in urine for 5 hours on 6/9/15. The resident stated, "...I don't like peeing on myself. I like to be up at 7:00 [AM] not 12:30 [PM]. Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room when asked if there was enough facility staff to meet the required care for the residents, the DON stated, "I can't say that we've met everyone's needs."	F 224		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225	F225 The facility will ensure that all injuries of unknown sources are reported immediately to the administrator of the facility. The facility will have evidence that all alleged violations have been investigated. The results of all investigations will be reported to administrator or their designee to determine need to report further to state or law enforcement officials. Corrective Action Residents#11 and #13 incident reports were reviewed with nursing staff involved to determine appropriate investigative procedures. The Occurrence Review report form was modified to provide for better investigations of incidents of unknown origin explanation. All nurses were in-serviced on use of the form and provided with investigation tools to utilize moving forward. Education will be documented. Method of Correction for all residents All incident reports from the last 3 months to be reviewed for any need of investigation and to be used in the education of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 11 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, interview, and review of the Occurance Report, the facility failed to investigate an incident involving an injury for 2 (Resident #11 and 13) of 17 residents reviewed. The findings included: Review of the facility policy Fall Committee Protocol, undated, revealed "...Staff on duty prior to incident being noticed ie; skin tear or bruising, will be asked to provide statements..." Medical record review revealed Resident #11 was admitted to the facility on 6/5/14 with diagnoses including Dementia with Behavioral Disturbances, History of Falls, Dysphagia, Muscle Weakness, Depression, Congestive Heart Failure and	F 225	F225 continued investigation for Nurses. All incidents moving forward from June 19, 2015 are reported on the new occurrence review report, which provides a protocol of investigation of incidents without known origin. All incident reports are reviewed by Nurse Management daily and the ORC (Occurrence Review committee) at their weekly meeting to determine need for further investigation. QAPI and monitoring At the ORC meetings weekly, an audit tool that checks for type of injury/ is it witnessed or unknown/ were employee investigations done for prior 24 hours of incident/nurse involved/follow up necessary will determine compliance. Any discrepancies will be reviewed to determine need for counseling or further education of staff. Compliance threshold will be 95% correct reporting. ORC committee to monitor and report compliance to QAPI meetings for recommendation's or need for modifications. Completion Date Occurrence Report form revised **6/19/15** Review of last 3 months of incident reports **7/10/15** Staff Education Provided on use of forms **6/19/15-6/23/15** Audit Tool for Monitoring of Occurrence Reports developed and utilized **6/30/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 12 Diabetes Mellitus. Medical record review of a Quarterly Minimum Data Set (MDS) dated 3/10/15 revealed Resident #11 was severely cognitively impaired and was total care for Activities of Daily Living. Observation on 6/4/15 at 1:09 PM revealed Resident #11 seated in a geriatric chair in the hallway outside her room. Continued observation revealed a healing skin tear on the resident's right forearm that was half-moon shaped, red with edema and bruising. The surveyor requested all incident investigations for the last 4 months for Resident #11 on 6/4/15 at 1:40 PM from the Administrator. Interview with the Administrator on 6/4/15 at 4:20 PM at the 1 West nurses station confirmed there were no incident investigations for Resident #11's skin tear. Continued interview confirmed the facility failed to investigate the skin tear. Medical record review revealed Resident #13 was admitted to the facility on 8/25/11 with diagnoses including Dementia, Dysphagia, Osteoporosis, Psychosis, and Muscle Weakness. Medical record review of a Quarterly MDS dated 4/4/15 revealed Resident #13 had severe cognitive impairment and required total assistance with Activities of Daily Living. Medical record review of a Nurse's Note dated 3/16/15 at 11:50 AM documented "...CNT [Certified Nurse Technician/ Aide] called nurse to pt's [patients] room, 2 purplish discolorations quarter & [and] dime size noted to upper right	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 13 arm, unknown origin..." Review of a facility Occurrence Report dated 3/16/15 documented "...type of occurrence...unknown bruise..." Continued review revealed "...document probable cause for this occurrence...unknown...per investigation resident combative during care & transfers..." Continued review revealed an employee statement attached to the Occurrence Report dated 3/16/15, signed by CNA #2, "...I found the bruise while doing personal care..." Continued review revealed no statements written by staff on duty from previous shifts. Medical record review of a Nurse's Note dated 3/29/15 at 1:00 PM documented "...noted slight green discoloration to (L) [left] cheek area. Resident had been scratching @ [at] earlier this AM..." Review of a facility Occurrence Report dated 3/29/15 at 1:00 PM documented "...type of occurrence...unknown...bruise..." Continued review documented "...possible caused when scratching face..." Continued review revealed an employee statement attached to the Occurrence Report dated 3/29/15, signed by Licensed Practical Nurse (LPN) #1, "...was scratching @ area during meds [medication administration] this AM..." Continued review revealed no statements written by staff on duty from previous shifts. Medical record review of Nurse's Notes dated 3/30/15 at 10:00 PM and on 3/31/15 at 10:40 PM documented a bruise to the left jawline. Continued medical record review revealed no Occurence Report related to the bruise on the left jawline.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 14 Interview with LPN #3 in the Administrator's office on 6/9/15 at 1:55 PM, when asked if there was an Occurence Report for the injury of unknown origin on 3/31/15, stated, "...it's probably the same area as the incident on 3/30/15...just staff describing it differently..." When asked if statements had been obtained, per facility policy, from staff who were assigned to the resident prior to notice of injury, LPN #3 stated, "...no...we did not get statements...a team meets every week and we discuss all the incidents...bruises, falls or whatever..." When asked if an investigation had been conducted, and statements written by staff on duty from previous shifts had been obtained, to determine the cause of the injuries of unknown origin on 3/16/15, 3/29/15 and 3/30/15, LPN #3 stated, "...no...we did not..."	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation and interview, the facility failed to ensure the dignity and respect of 4 (Resident #10, 14, 15, 17) of 17 residents reviewed. The findings included: Review of the undated facility policy "Quality of	F 241	F241 The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Corrective Action Nursing staff provided education on dignity needs being met with examples provided from survey conducted June 2015 regarding resident needs not being addressed for feeding and toileting and basic grooming. All situations involving observations of residents 10/14/15/17 were reviewed to determine staff needing counseling/guidance or training in resident needs. Education to be provided on resident needs and neglect as a form of abuse. Resident needs for toileting and assistance in feeding and grooming to be reviewed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 15 Life in the Nursing Home Setting" revealed "Dignity: The facility must promote care for residents in a manner and environment that maintains or enhances each resident's dignity..." Further review revealed the staff was to "...Groom resident as they wish to be groomed...Assist residents to dress...appropriate to the time of day and individual preference...Assist resident to bathroom...Allow privacy while toileting and check on them frequently if safety concern noted...Check incontinent residents frequently and toilet as often as needed..." Medical record review revealed Resident #10 was admitted to the facility on 12/10/13 with diagnoses including Cerebrovascular Accident, Dysphagia, Muscle Weakness, Incoordination, Joint Contracture, and Dementia. Medical record review of a Quarterly MDS dated 3/10/15 revealed Resident #10 had moderate cognitive impairment, required set-up help and supervision for eating and had range of motion impairment of one upper and lower extremity. Observation of Resident #10 on 6/3/15 at 12:56 PM in the 2nd floor dining room revealed Resident #10 was seated in a wheelchair at a table with 7 other residents. Continued observation revealed 3 staff were seated with their backs to the 7 residents and were providing feeding assistance to 5 other residents. Continued observation revealed Resident #10 took an unpeeled banana with her right hand and used her teeth to open the banana and unpeeled it, then started eating the banana. Continued observation revealed the staff failed to assist the resident with the meal.	F 241	F241 continued Method of Correction for all residents Nurse management or their designee. The list will be reviewed and updated as needed by MDS Nurse and provided for nurses stations to share with CNT staff. All staff provided education on dignity needs being met with examples provided from survey conducted June 2015 regarding resident needs not being addressed for feeding and toileting and basic grooming. Nurse Management and selected staff members to review all resident toileting needs to determine how much assistance is needed. Each nurses station will be provided an updated list each month of residents and their level of assistance in toileting. The list will be updated as needed by MDS nurse. Nursing Administration reviews staffing coverage daily and to ensure resident needs are met throughout the day by assigning a hall monitor making random checks on residents listed as having toileting needs. As issues are found or reported, staff will be counseled and educated on care needs for that resident and will be asked to provide assurance of care personally to the resident and their family.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 16 Observation of Resident #10 on 6/11/15 at 8:19 AM in her room revealed she was in bed with meal tray on the over bed table to her right side and she was only able to reach the milk and the banana. Continued observation revealed the unopened orange juice and jelly, 2 bowls of oatmeal, and the main plate of food were not within reach. Interview with the Director of Nursing (DON) on 6/11/15 at 8:25 AM in the resident's room, when asked if the resident's tray had been set-up within the resident's reach stated, "...no...she can't reach it..." Medical record review revealed Resident #15 was admitted to the facility on 6/14/13 with diagnoses including Dementia, Abnormal Posture, Hypertension, Oral Dysphagia, Hallucinations, Anxiety with Depression. Review of the Annual MDS dated 6/3/15 documented the resident had long and short term memory impairment and required extensive assistance from 1 person for bed mobility, transfers, dressing and toileting. The resident was totally dependent and required assistance from 1 person for eating, personal hygiene and bathing. The resident was always incontinent of bladder and bowel. Observation of Resident #15 on 6/3/15 at 12:57 PM in the 1st floor dining room revealed the resident was seated in a reclining Geri-chair and had just finished her lunch. The resident stated, "I have to go to the bathroom." The Activities Director stated, "You'll have to wait until a tech can take you." Further observation revealed the	F 241	F241 continued Administrator or designee will make rounds during meals to ensure that proper feeding practices are in effect to promote dignity. All management staff will be provided monitoring tools for compliance as they make rounds. All staff will be in serviced on Dignity annually and at orientation. This education will be documented. Staffing schedules will be reviewed by Nurse management or their designee daily to ensure staff assignment and staffing level are in place. Nursing staff to have documented in-services on appropriate incontinent care and dining assistance. QAPI and monitoring DON or designee will review ADL documentation on toileting to ensure proper adherence of incontinence care at least weekly until compliance threshold of 85% is reached and then monitoring will be done at least monthly to assure continued compliance. The monitoring tool use on random audits to view compliance for incontinence care will include resident name, room number, day and time of day, resident mental	

CORRECTED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 17 Activities Director asked the Activities Assistant to take the resident to her room. The Activities Assistant was taking another resident out of the dining room and said she would when she returned. The Activities Assistant returned at 1:05 PM and pushed Resident #15 in the Geri-chair out of the dining room into the hallway beside the resident's room and left her sitting there. Continued observation revealed the resident was lying in the recliner with her eyes closed, and stated, "take it off, it hurts." Continued observation revealed no one came to assist the resident. At 1:30 PM CNA #13 was asked by the surveyor to check the resident for incontinence. The resident was moved into the room, placed on the bed, and was found to be incontinent of urine. Interview with CNA #13 at 1:37 PM in room 110 A confirmed the resident was incontinent of urine and the facility failed to provide care and maintain the dignity of Resident #15. Medical record review revealed Resident #17 was admitted to the facility on 1/31/08 with diagnoses including History of a Cerebral Vascular Accident resulting in Left Sided Hemiplegia, Chronic Cervical Pain, Chronic Obstructive Pulmonary Disease, Diabetes, and Anxiety. Review of the Quarterly MDS dated 4/12/15 documented the resident was cognitively intact, and required extensive assistance from 1 person for bed mobility, transfers, dressing, toileting and personal hygiene. The resident was totally dependent for bathing, occasionally incontinent of urine and always continent of bowel. Interview with the resident on 6/9/15 at 12:55 PM in the 1st floor dining room revealed the resident	F 241	F241 continued orientation, comments from resident and if resident is dry. Audits will be conducted weekly. Compliance will be met when 90% report toileting needs have been addressed. Findings/recommendations will be shared with the QAPI committee for further monitoring. Monitoring will be done by Nurse Management or their designee. Each nurses station will be provided a updated list each month by Nurse Management of residents and their level of assistance in toileting. These lists will be used as a part of the audit conducted weekly. Audit tool developed to monitor residents on Red napkin program to assure assistance is being provided at meal service. Tool will include resident name/date/meal served/where resident is eating/service need and provided. Administrator or designee will conduct audit averaging two times each week and will provide compliance to QAPI committee meetings. Compliance threshold will be 90%. Findings will be reviewed at QAPI meeting with compliance reported and discussed for further need of interventions or training. Administrator or designee to monitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 18 had not been assisted out of bed, dressed, or toileted until 12:30 PM. The resident revealed her normal routine was to be up, bathed, and dressed by 7:00 or 7:30 AM. Continued interview revealed the resident had pushed her call light 3 different times to ask for assistance to get up out of bed and to be assisted to the bathroom. Continued interview revealed LPN #6 was working as a CNA, and had answered her call light each time and stated, "I'm passing trays...I'm picking up trays...we don't have enough staff today, we'll get to you as soon as we can..." Continued interview revealed even after the resident had told the LPN she needed to go to the bathroom and later that she was wet, no assistance was provided. The resident became incontinent of urine and had to lie in her saturated bed for 5 hours. Interview with LPN #6 on 6/9/15 at 1:50 PM in the 1 West nurses station confirmed he was working as a CNA. The LPN stated,"The residents want to be up by 7:00 AM, and nights are supposed to get them up but there isn't enough staff." Continued interview confirmed the LPN did answer the call light for Resident #17 on 3 different times that day and did not provide assistance with transfers and toileting, and failed to provide hygiene care/bathing and dressing after the resident explained she had become incontinent. Interview with CNA #5 on 6/10/15 at 2:40 PM in the pharmacy room confirmed Resident #17 was alert, had a set morning routine, was able to make her needs known and normally continent of urine. Interview with Resident #17 on 6/11/15 at 11:00 AM in the resident's room confirmed she had to lie in urine for 5 hours on 6/9/15. The resident	F 241	F241 continued Completion Date Resident lists reviewed/ updated on toileting needs **7/15/15** Staff educated on dignity/care issues of residents during meal times **7/10/15** Audit tools developed toileting audit and dining audit **7/7/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 19 stated, "...I don't like peeing on myself...I like to be up at 7:00 [AM] not 12:30 [PM]...I just had to lay there wet and I hate it...made me feel pitiful, awful, and I hate it..."	F 241	F253 The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation and interview, the facility failed to ensure housekeeping and maintenance services in resident areas on the 2nd floor, and in rooms 101 and 133 were maintained to ensure a sanitary and comfortable environment. The findings included: Review of the facility policy "Housekeeping" dated 4/15/14, revealed "...Two housekeepers on each floor will clean resident rooms..." Further review revealed "...The following are daily assigned tasks for the housekeepers assigned to resident rooms...Sweep...and mop [floors] as needed but no less than once per week, both the resident room space and the bathrooms...Resident dining rooms is cleaned after breakfast and lunch meals and first thing each morning. The area is swept and mopped before each meal..." Observation and interview with the Administrator, on 6/4/15 at 8:50 AM, on the 2nd floor by the dining room, confirmed floor perimeters by the	F 253	Corrective Action 2nd Floor Dining room floor perimeters were cleaned after surveyor and administrator viewed area. Housekeeping supervisor was instructed to ensure that daily cleaning along base boards was checked and cleaned as needed. Rooms 212, 216, 219, 223, 224, 227, 228, 230, 232, 233, 235, 238 were cleaned to include accumulation of dirt along perimeter. Staff who were assigned the rooms to be cleaned have been counseled and educated accordingly. Room 101 had dry wall repaired around PTAC unit and at window and all new flooring replaced. Room 133 had drywall repaired and painted. Method of Correction for all residents Housekeeping scheduled protocol to be reviewed with all housekeepers with documented in-service. All rooms to have documented inspection for accumulation of dirt along baseboard perimeters by Housekeeping Supervisor and Administration and cleaned accordingly. Housekeepers to document rooms cleaned each day on cleaning log list and turn report into Housekeeping Supervisor or designee.	

F253 continued
Complaint Survey ending 6/16/15
Claiborne and Hughes #445157

QAPI and monitoring

Audit tool created to include room number/day/time inspected/staff assigned an a list of specific cleaning tasks for each room. Housekeeping supervisor or designee will conduct random room audits for cleanliness three different days of the week. Any noncompliance will be addressed immediately with staff member involved. Audits will be reviewed each week with Administrator until 80% compliance is met with rooms audited. At that stage, audits will be reviewed monthly. Findings/recommendations will be shared with the QAPI committee for further monitoring/education. Monitoring will be done by Housekeeping supervisor or designee.

Completion Date Dry wall repaired on rooms 101 and 133 **6/12/15**

Housekeeping staff education on room cleaning protocol and use of cleaning log **7/8/15**

Audit tool developed/utilized **7/9/15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 20 baseboards had a heavy accumulation of blackened debris in 12 out of 26 occupied resident rooms, #212, 216, 219, 223, 224, 227, 228, 230, 232, 233, 235 and 238, and the dining room. Further interview stated, "the floors are dirty" and the facility failed to follow their policy. Observation and interview with the Housekeeping Supervisor, on 6/9/15 at 8:15 AM, in rooms 101 and 133, confirmed the drywall on the right side of the air conditioning units above the baseboard were wet and had wall penetration.	F 253		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow a physician's order for nebulizer therapy for 1 (Resident #2) of 17 residents reviewed. The findings included: Medical record review revealed Resident #2 was admitted to the facility on 12/27/12, and a readmission date of 5/18/15 with diagnoses including Pneumonia, Acute Asthmatic Bronchitis, Cerebrovascular Accident, Chronic Obstructive Asthma, Hypertension, Depression, and Anxiety. Observation on 6/8/15 at 11:05 AM and at 12:10 PM in the resident's room revealed Resident #2 lying in bed, eyes closed, and a nebulizer mask	F 281	F281 The services provided or arranged by the facility will meet professional standards of quality. Corrective Action LPN in question was educated on proper protocol for Nebulizer treatment which includes observation of treatment. Resident #2 received no adverse effect from the nebulizer treatment in question. Method of Correction for all Residents MD orders for nebulizer treatments to be reviewed to assure orders are plotted correctly on MARs and that treatments are administered as ordered. Licensed Nurses to be provided documented education on following physician orders on prescribed times for nebulizer treatment as well as nebulizer treatment protocol.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 21 over his nose and mouth and the nebulizer machine was turned on. Medical record review of Physician's Orders for 6/1 - 30/15 documented "...DuoNeb (works by relaxing and widening the airways in the lungs, which helps you to breathe more easily) 2.5 - 0.5 mg [milligram]/3 ml [milliliter] solution use 1 vial by inhalation 4 times daily at 9:00 AM...1:00 PM...5:00 PM...9:00 PM..." Interview with Licensed Practical Nurse (LPN) #5 on 6/8/15 at 12:15 PM on 2nd floor hallway outside the dining room, when asked about the process and length of time for a nebulizer treatment, stated, "...takes about 10 minutes...wait for it to finish..." When asked how often Resident #2 received a nebulizer treatment on the 7:00 AM - 3:00 PM shift, LPN #5 stated, "...once in the morning and once in the afternoon..." When asked about the observation of treatment at 11:05 AM and at 12:10 PM, LPN #5 stated, "...oh...sorry..." and walked away. Medical record review of Scheduled Med (Medication) Administration Records for 06/2015 revealed DuoNeb 2.5 - 0.5 mg/3 ml solution was initialed by LPN #5 on 6/8/15 at 9 AM and at 1 PM, indicating the medication was administered. Interview with the Director of Nursing on 6/9/15 at 9:00 AM in the pharmacy room, after describing observations of nebulizer mask in place at 11:05 AM and at 12:10 PM, stated, "...that should not have happened..." Interview with LPN #5 on 6/15/15 at 8:53 AM at 2 West nurses station, when asked about Resident #2's nebulizer treatment on 6/8/15, LPN #5	F 281	F281 continued QAPI and monitoring Nurse Management or their designee will perform random rounds to audit those on nebulizer treatments using an audit tool that records resident name/room number/Physician order time/time administrated/proper protocol followed. Any noncompliance will be corrected at time of occurrence and documented education provided. Audits will be conducted weekly until compliance will be met when 100% is accomplished, then random monthly audits will be done to assure continued compliance. Findings/recommendations will be shared with the QAPI committee for further monitoring. Monitoring will be done by Nurse Management or their designee. Completion Date Audit of all nebulizer treatments **7/1/15** Documented nursing education on nebulizer **7/10/15** Audit tool developed **07/10/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 22 stated, "...as you can see I do the dining room in the morning...just not enough time...that was the 9 AM treatment that I started at 11..." LPN #5 confirmed the medication was administered out of the acceptable time range.	F 281		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on facility policy review, Shower/Bath Schedule review, medical record review, observation, interview and review of the Activity of Daily Living (ADL) Flow Log, the facility failed to follow the care plan for ADL needs involving showers, meal assistance, and continence care for 6 (Residents #1, 10, 13, 14, 15, 17) of 14 residents reviewed requiring ADL assistance. The findings included: Review of the facility Red Napkin Protocol, with the revision date of 5/27/15, revealed "...Residents determined to have significant and/or potential problem with weight loss/eating/nutrition/...will be placed on the Red Napkin Program..." Further review revealed "...A red napkin will designate resident at risk and will serve as a visual reminder to staff...to provide over-site and monitoring during meals...To cue/assist/remind resident to eat each meal...Offer substitution when food is not being	F 282	F282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. Corrective Action LPN #6 was provided documented education on the red napkin protocol. Resident #1 bathing schedule was reviewed with nursing staff providing care. Because of resident's non-compliant behaviors during bath time (which include continued screaming, agitation and hitting at staff), staff to be provided with alternate diversional techniques to attempt; and to be instructed to work with nurse in coordination of bath time. Resident #10's bathing schedule was reviewed with nursing staff providing care. Staff have been instructed to work with nurse when resident is uncooperative. Red Napkin protocol for resident #10 was reviewed with nursing staff working second floor dining area to assure their understanding.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 23 eaten..." Review of the facility Shower/Bath schedule revealed the shower/bath was assigned according to the resident's room number. Further review revealed no showers were scheduled for Sundays. Medical record review revealed Resident #1 was admitted to the facility on 11/4/13 with diagnoses including Odontoid Fracture/Cervical Spine, Bipolar with Psychotic Behavior, Depression, Dysphagia, Parkinson's Disease, Dementia with Behavioral Disturbances, Hemiplegia, Diabetes Mellitus, Advanced Alzheimer's Disease. Medical record review of the Annual Minimum Data Set (MDS) dated 11/9/14 documented Resident #1 was cognitively impaired, could make self understood and understood others. Further review documented the resident was totally dependent and required 1 person assistance for bed mobility, transfers, eating, toileting, personal hygiene and bathing. Further review documented the resident was frequently incontinent of the bowel and always incontinent of the bladder. Medical record review of the Quarterly MDS dated 5/10/15 documented Resident #1 was severely cognitively impaired, usually could make self understood and usually understood others. Further review documented the resident required extensive assistance of 1 person for bed mobility, eating, toileting, and personal hygiene. Further review documented the resident remained totally dependent with 1 person assistance for transfers and bathing and was always incontinent of the bowel and bladder.	F 282	F282 continued Resident #13 bathing schedule was reviewed with nursing staff providing care. Because of resident's non-compliant behaviors during bath time (which include loud cursing, agitation and hitting at staff), staff to be provided with alternate diversional techniques to attempt; and to be instructed to work with nurse in coordination of bath time, as well as solicit family assistance. Resident #14 will be offered at least 2 meals each day in the dining room. Her care plan was changed to reflect that. Her bathing schedule was reviewed with nursing staff providing care. Staff were instructed that if resident refused bathing care or if bathing was unable to be given that they must inform charge nurse or supervisors to arrange for alternate schedule. Resident #15 toileting needs were discussed with Activity staff member in question to assure that she followed up with nursing staff assigned resident's care for getting her toileted. All staff have been instructed to seek nursing staff when toileting needs are mentioned by residents. Bathing needs for resident were changed to bathing room that can accommodate a bathing stretcher. Staff to be instructed to notify Nurse Management when such issues arise.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 24 Medical record review of the care plan with the original date of 11/10/14, with an updated goal date of 5/5/15, documented Resident #1 had "...Impaired Activities of Daily Living, At risk for further decline/Requires assistance..." Further review documented interventions including "...follow schedule for showers and bed baths weekly...Assistance required with transfers, toileting...bed mobility, and personal hygiene...Report refusals to nurse..." Observation on 6/8/15 at 7:59 AM in Resident #1's room revealed Licensed Practical Nurse (LPN) #6 attempting to feed the resident. Further observation revealed a red napkin on the resident's tray. Interview with LPN #6 on 6/8/15, at 8:00 AM in Resident #1's room, when asked the significance of the red napkin stated, "...was not sure of what the red napkin means..." Review of the medical record documented Resident #1 was in room 123 A prior to 5/22/15 and changed to room 120 B after 5/22/15. Review of the Shower/Bath Schedule documented room 123 A was scheduled for Tuesday, Thursday and Saturday at 7:00 AM-3:00 PM and room 120 B was scheduled for Tuesday, Thursday and Saturday at 3:00 PM-11:00 PM. Review of the ADL Flow Log documented Resident #1 received a shower 4 out of 14 opportunities in January 2015; 5 out of 12 opportunities in February 2015, 4 out of 13 opportunities in March 2015, 0 out of 13 opportunities in April 2015, 1 out of 13	F 282	F282 continued Resident #17 get up schedule and grooming time have been reviewed with her. Social Services is working with resident to establish a time that can best meet her expectations that does not conflict with breakfast for all residents. Care plans for residents 1,10,13,14,15,17 were reviewed with staff and updated to reflect proper interventions for care needed. Method of Correction for all residents Each resident's bathing schedule will be reviewed with the resident (if cognitively able) to assure bathing needs are met as needed/desired. Administrator to assign task force members to interview residents, when possible and families when needed to attain this information. Results will be shared with MDS nurse to reflect any changes needed for Care plan and MDS nurse will update staff on any modifications necessary for providing bathing care. Nurse Management will review and adjust bathing schedules posted at nurses stations and in the Care Tracker computers and communicate and educate CNT staff on complying with the bathing schedules for residents and the protocol for documenting correctly, dealing with refusals and reporting concerns to charge nurse. All education will be documented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 25 opportunities in May 2015, and 1 out of 6 opportunities from June 1-15, 2015. Interview with LPN #13 on 6/9/15 at 2:12 PM at the 1 East nurses station when asked why Resident #1 received 1 shower in the past 2 months stated, "I didn't know she hasn't had a shower at all...techs [Certified Nurse Aides] usually tell me when [resident] refuses." Interview with the Director of Nursing (DON) on 6/15/15 at 3:20 PM and 6/16/15 at 1:00 PM in the pharmacy room when asked if Resident #1 received showers per the Shower/Bath Schedule or the care plan confirmed, "...no shower had been provided 3 times a week as scheduled...no shower provided per the care plan..." Medical record review revealed Resident #10 was admitted to the facility on 12/10/13 with diagnoses including Cerebrovascular Accident, Dysphagia, Muscle Weakness, Incoordination, Joint Contracture, and Dementia. Medical record review of a Quarterly MDS dated 3/3/15 documented Resident #10 had moderate cognitive impairment, required set-up help and supervision for eating and had range of motion impairment of one upper and lower extremity (left side). Further review documented Resident #10 required total assistance of 1 person for bathing. Medical record review of an ADL Flow Sheet Log dated 5/1 - 31/15 documented Resident #10 had received 1 shower. Medical record review of a care plan dated 12/15/14 documented "...at nutritional risk r/t [related to] dementia...interventions...red napkin	F 282	F282 continued Nursing assignments/schedules to be reviewed by Nurse Management to ensure that adequate staffing coverage is in place. Facility has secured additional agency staffing to minimize any staff openings. Nurse Management will report staffing levels to Administration daily to ensure adequate levels are in place for care. Weekly, Administration and Nurse Management will review staffing needs for prior week and forecast needs for upcoming week to ensure that adequate staffing levels are maintained. Facility to initiate care cards which will be posted in secure places at each resident's bedside. The cards will provide key ADL information for all staff providing care. Cards will be updated by MDS nurse or designee and all Nursing staff will be provided documented education on the card's use. IDT team with coordination from MDS nurse will review and update care cards as needed. Nursing staff will be re-educated on the Red Napkin policy with attendance documented. All food carts will be provided with signage noting " Trays with Red Napkins note that the individual needs specific assistance, cueing or encouragement to eat, which staff must provide."	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 26 program...encourage to eat 75-100% of meals daily..." Observation of Resident #10 on 6/3/15 at 12:56 PM in the 2nd floor dining room revealed the resident was seated in a wheelchair at a table with 7 other residents. Continued observation revealed 3 staff, assisting other residents, were seated with their backs to the 7 residents. Continued observation revealed Resident #10 took an unpeeled banana with her right hand and used her teeth to open the banana and unpeeled it, then started eating the banana. Continued observation at 1:22 PM revealed Resident #10 had eaten the banana and a few bites of food on the plate and self-propelled out of the dining room and staff did not encourage her to continue eating her meal per the care plan. Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room when asked if there was enough facility staff to meet the required care and services for the residents, the DON stated, "...I can't say that we've met everyone's needs..." Medical record review revealed Resident #13 was admitted to the facility on 8/25/11 with diagnoses including Dementia, Dysphagia, Osteoporosis, Psychosis, and Muscle Weakness. Medical record review of a Quarterly MDS dated 4/4/15 documented Resident #13 had severe cognitive impairment and required total assistance of 1 for bathing. Medical record review of a care plan dated 7/7/14 documented "...impaired ADL's/at risk for decline...interventions...follow schedule for showers and bed baths..."	F 282	F282 continued Larger signs will also be posted at key spots in both dining rooms. Administrator or designee will make rounds during meals to ensure that proper feeding practices are in effect to promote dignity. All management staff will be provided monitoring tools for compliance as they make rounds. QAPI and monitoring Audit tool developed to monitor residents on Red napkin program to assure assistance is being provided at meal service. Tool will include resident name/date/meal served/where resident is eating/service need and provided. Administrator or designee will conduct audit averaging two times each week and will provide compliance to QAPI committee meetings. Compliance threshold will be 90% and audits will be continued weekly until compliance is obtained and then be done monthly. Findings will be reviewed at QAPI meeting with compliance reported and discussed for further need of interventions or training. Administrator or designee to monitor. Audit tool for bathing compliance to be developed to assure residents are getting bathing care as per care plan. Tool will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 27 Medical record review of an ADL Flow Sheet Log dated 5/1 - 31/15 documented Resident #13 had received 2 showers. Interview with CNA #2 on 6/15/15 at 2:45 PM in a break room on the 2nd floor, when asked if assigned residents received their showers according to the schedule, confirmed "...no...not enough time to do showers..." Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room when asked if there was enough facility staff to meet the required care and services for the residents, the DON stated, "...I can't say that we've met everyone's needs..." Medical record review revealed Resident #14 was admitted to the facility on 8/6/14 with diagnoses including Alzheimer's, Dementia with Behaviors, Gait Difficulties, Muscle Weakness and Depression. Review of the Quarterly MDS dated 2/15/15 documented the resident was severely cognitively impaired and required extensive assistance from 1 person for bathing, extensive assistance from 2 people for transfers and assistance from 1 person for eating. Medical record review of the comprehensive care plan dated 10/9/14 documented a problem of "Impaired ADL's". Interventions included, "...follow schedule for showers...staff to anticipate and meet all needs on a daily basis...encourage to use call light for needs..." Continued review of the comprehensive care plan documented a problem of "...Comfort Care related to resident decline..."	F 282	F282 continued include resident name/date and day/room number/bath schedule/bathing care given/ nurse verifying/ documentation of non compliance (as noted). Nurse management or designee will conduct audit randomly at least two times per week and will provide compliance to QAPI committee meetings. Compliance threshold for bathing will be 75% and audits will be continued weekly until compliance is obtained and then be done monthly to assure continued compliance. Findings will be reviewed at QAPI meeting with compliance reported and discussed for further need of interventions or training. MDS nurse to conduct a one time audit of care plans for all residents on Red Napkin program to assure proper interventions are in place and have been presented to Nursing staff providing assistance. MDS nurse to monitor randomly staff awareness and use of the Care Cards. Monitoring of updates on care cards will occur after each quarterly care plan review, or as necessary. MDS nurse to monitor. MDS nurse will conduct a one time audit of care plans of resident bathing needs and include information of assistance needed, bathing preferences and interventions necessary and have been presented to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 28 Interventions included, "...Provide Support...Provide additional assistance with ADL's as condition declines..." Observation on 6/3/15 at 7:53 AM in the resident's room revealed the resident was sitting in her wheelchair (WC) with a pureed breakfast tray sitting on the over the bed table in front of her. The resident had a red napkin which designated the resident needed additional assistance with meals and observation. There was no one present to coach or cue the resident. Continued observation revealed the resident was trying to drink from an unopened carton of orange juice. Further observation at 8:09 AM revealed the resident had not eaten anything, the orange juice was still unopened, she was not eating, and no one was present to assist the resident. Observation on 6/8/15 at 8:35 AM in the resident's room revealed the resident was in the bed, her pureed breakfast tray was on the over the bed table in front of her. The resident's head was lying against the right upper side rail. Milk was spilled on the food and on the tray. The resident was patting the food with her hands. There was food and pepper on her gown, both hands, and forearms. The resident held out her hands and said, "please help me, it hurts, it feels like it's going to crack, please help me, go get somebody, tell them I said." The resident was alone. Continued observation revealed LPN #12 walked past the resident's room at 8:38 AM. CNA #10 looked into the room and kept on walking down the hall at 8:42 AM. CNA #5 entered the room at 8:48 AM and removed the uneaten breakfast tray. Review of the Shower/Bath Schedule revealed	F 282	F282 continued Nursing staff providing assistance. Monitoring of updates on care cards will occur after each quarterly care plan review, or as necessary. MDS nurse to monitor. Completion Date Audits of all care plans for Red Napkin and bathing needs **7/10/15** Implementation of care cards in conjunction with education of staff **7/30/15** Nursing education on Red Napkin program and meal service protocol **07/14/15** Nursing Education on compliance of bathing needs for all residents **07/18/15** Conducting and dining audits **07/10/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 29	F 282		

Resident #14 was to receive a shower every Monday, Wednesday, Friday on the 3 PM to 11 PM shift.

Interview with CNA #5 on 6/10/15 at 2:40 PM in the pharmacy room confirmed Resident #14 was dependent on staff for all of her needs and unable to use the call light to ask for assistance. The CNA confirmed the resident required her meals to be set up and required cueing or prompting in order for the resident to eat most of her meal. The CNA confirmed the resident was not receiving a shower 3 times per week as the shower schedule and care plan stated.

Interview with LPN #12 on 6/11/15 at 3:30 PM in the pharmacy room confirmed "showers are not being done" as scheduled.

Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room when asked if there was enough facility staff to meet the required care for the residents, the DON stated, "I can't say that we've met everyone's needs."

Medical record review revealed Resident #15 was admitted to the facility on 6/14/13 with diagnoses including Dementia, Abnormal Posture, Hypertension, Oral Dysphagia, Hallucinations, Anxiety with Depression.

Review of the Annual MDS dated 6/3/15 documented the resident had short and long term memory loss. The resident was totally dependent and required assistance from 1 person for personal hygiene and bathing. The resident was always incontinent of bladder and bowel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 30 Medical record review of the comprehensive care plan dated 6/3/15 documented a problem of "...Impaired ADL's at risk for further decline..." with interventions including, "...Follow schedule for showers...Staff to anticipate and meet all needs on a daily basis...Assistance required with transfers, toileting, dressing, bed mobility, and personal hygiene..."Continued review documented a problem of "...Resident is Incontinent of Bowel and Bladder-Risk for recurrent UTI..." Interventions included, "...Provide daily care for resident...Provide incontinent care as needed...Turn and reposition while in bed or in chair for comfort and to reduce risk of impaired skin..." Observation of Resident #15 on 6/3/15 at 12:55 PM in the 1st floor dining room revealed the resident was seated in a reclining Geri-chair, and had just finished being assisted with her lunch by the Activities Director. Continued observation at 12:57 PM revealed the resident stated, "I have to go to the bathroom." The Activities Director stated, "You'll have to wait until a tech [CNA] can take you." Continued observation revealed the Activities Director asked the Activities Assistant to take the resident to her room. The Activities Assistant was taking another resident out of the dining room and said she would when she returned. The Activities Assistant returned at 1:05 PM and pushed Resident #15 in the Geri-chair out of the dining room into the hallway beside the resident's room and left her sitting there. Continued observation revealed the resident was lying in the recliner with her eyes closed, and stated, "take it off, it hurts." No one came to assist the resident. At 13:30 PM CNA #13 was asked by the surveyor to check the resident for incontinence. The resident was moved into the	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 31	F 282		

room, placed on the bed, and was found to be incontinent of urine.

Interview with CNA #13 at 1:37 PM in room 110 A confirmed the resident was incontinent of urine and the facility failed to provide care according to the care plan for Resident #15.

Medical record review of the Bath/Shower Schedule revealed Resident #15 was to receive a shower every Tuesday, Thursday and Saturday.

Interview with CNA #10 on 6/10/15 at 2:40 PM in the pharmacy room confirmed the resident was not receiving showers per the Bath/Shower schedule as the shower room was too small to accommodate a shower stretcher, and the resident could not tolerate sitting upright on the shower chair.

Interview with LPN #12 on 6/11/15 at 3:30 PM in the pharmacy room revealed the resident had been in her recliner all day (6/11/15) and had not been changed or repositioned per the care plan; the facility failed to provide incontinence care and repositioning for Resident #15.

Medical record review revealed Resident #17 was admitted to the facility on 1/31/08 with diagnoses including History of a Cerebral Vascular Accident resulting in Left Sided Hemiplegia, Chronic Cervical Pain, Chronic Obstructive Pulmonary Disease, Diabetes, and Anxiety.

Review of the Quarterly MDS dated 4/12/15 documented the resident was cognitively intact, and required extensive assistance from 1 person for bed mobility, transfers, dressing, toileting and personal hygiene. The resident was totally

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 32 dependent for bathing, occasionally incontinent of urine and always continent of bowel. Medical record review of the comprehensive care plan dated 10/13/14 revealed a problem of "...At Risk for Further Decline/Requires Extensive Assistance..." Interventions included, "...Assist resident to get up before 10:00 AM as she desires...Allow to make decisions and be as involved with care concerns and schedules as able...Staff to anticipate and meet all needs on a daily basis...Assistance required with transfers, toileting, dressing bed mobility, and personal hygiene...Encourage to use call light for needs..." Interview with the resident on 6/9/15 at 12:55 PM in the 1st floor dining room revealed the resident had not been assisted out of bed, dressed, or toileted until 12:30 PM. The resident stated her normal routine was to be up, bathed, and dressed by 7:00 or 7:30 AM. Continued interview revealed the resident had pushed her call light 3 different times to ask for assistance to get up out of bed and to be assisted to the bathroom. Interview with LPN #6 on 6/9/15 at 1:50 PM in the 1 West nurses station confirmed he was working as a CNA. The LPN stated, " The residents want to be up by 7:00 AM, and nights are supposed to get them up but there isn't enough staff." Continued interview confirmed the LPN did answer the call light for Resident #17 on 3 different times that day and did not provide assistance with transfers and toileting, and failed to provide bathing or dressing after the resident explained she had become incontinent.	F 282		
F 312 SS=F	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 33 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, Shower/Bath Schedule review, ADL (Activities of Daily Living) Flow Log review, interview, and observation, the facility failed to provide the ADL care necessary to meet the needs of 9 (Residents #1,4, 8, 10, 11, 13, 14, 15, 17) of 14 residents requiring ADL assistance for shower/bath, eating, and toileting. The findings included: Review of the facility Red Napkin Protocol, with the revision date of 5/27/15, revealed "...Residents determined to have significant and/or potential problem with weight loss/eating/nutrition/...will be placed on the Red Napkin Program..." Further review revealed "...A red napkin will designate resident at risk and will serve as a visual reminder to staff...to provide over-site and monitoring during meals...To cue/assist/remind resident to eat each meal...Offer substitution when food is not being eaten..." Review of the undated facility policy "Feeding the Impaired Resident" revealed "...Residents are assisted, as needed, to consume each meal so adequate nutrition is provided." Further review revealed the "...Arrange dishes and silverware so	F 312	F312 A resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. Corrective Action Resident #1 bathing schedule was reviewed with nursing staff providing care. Because of resident's non-compliant behaviors during bath time (which including continued screaming, agitation and hitting at staff), staff have been provided with alternate diversional techniques to attempt and instructed to work with nurse in coordination of bath time. Nursing staff were reminded to inform Charge nurse immediately if resident refused baths to determine if further interventions are needed. Resident #4 ADL needs were reviewed and care plan updated to show resident preferences for getting up. Charge nurse was educated to coordinate CNT staff in provision of care. Resident #8 Toileting and incontinence needs were reviewed and care plan modified as needed to show need for regular incontinence checks. CNT staff were counseled and re-educated on regular rounds to check for incontinence episodes. Resident #10 Red Napkin protocol for was reviewed with nursing staff working second	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 34 the resident can reach them easily...Open all cartons and give napkin to the resident...Feed slowly...Alternate foods and liquids, as desired and needed...Alternate foods...or supplements, should be offered...if the resident consumes less than half the meal...Clean the resident's mouth and hands when the meal is finished...Record the percentage (%) of food consumption, as 25%, 50%, 75%, or 100%..." Review of the undated facility policy "Bath/Shower" revealed "...each resident shall be kept clean routinely through the use [of] bed bathing or shower. Residents will have a bath/shower at least 2 times a week. Resident's choices will be taken into consideration as to what time of day and the day of the week that they would prefer...Refusals of bath/shower should be reported to their charge nurse. Continued refusals of bath/shower will be reported to family..." Review of the facility Shower/Bath schedule revealed the shower/bath was assigned according the the resident's room number. Further review revealed no showers were scheduled for Sundays. Review of the facility policy "Resident Call Lights" revealed "...It is the policy...for all employees to assist in the answering of call lights in a timely manner..." Further review revealed "...Staff to be alerted when the call lights sound...and work to respond within 5-7 minutes whenever possible. If a staff member who responds is not a nursing personnel and the request is nursing related, it is the staff member's responsibility to find a nursing personnel to answer the concern and follow up to assure situation is handled, when	F 312	F312 continued floor dining area to assure their understanding. Nursing staff were also educated about dignity issues for residents in need of assistance with food set up. Resident #11 clothes were changed and staff were also educated about dignity issues. Because of resident's non compliant behaviors during ADL care(cursing, agitation and hitting at staff), staff have been provided with alternate diversional techniques to attempt and instructed to work with nurse in coordination of bath time. Nursing staff were reminded to inform Charge nurse immediately if resident refused baths to determine if further interventions are needed. Resident #13 bathing needs were addressed with nursing staff who regularly provide her care. Because resident often exhibits non compliant behaviors during ADL care(cursing, and hitting at staff), staff have been provided with alternate diversional techniques to attempt and instructed to work with nurse in coordination of bath time. Nursing staff were reminded to inform Charge nurse immediately if resident refused baths to determine if further interventions are needed. Resident #14 will be offered at least two meals each in the dining room.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 35 possible...Whenever CNT [Certified Nurse Technician/Aide] staff go on break, they must inform their Charge Nurse or another staff member on that hall to assure that their call lights can be answered..." Medical record review revealed Resident #1 was admitted to the facility on 11/4/13 with diagnoses including Odontoid Fracture/Cervical Spine, Bipolar with Psychotic Behavior, Depression, Parkinson's Disease, Dementia with Behavioral Disturbances, Hemiplegia, Diabetes Mellitus, Advanced Alzheimer's Disease. Medical record review of the Annual Minimum Data Set (MDS) dated 11/9/14 documented Resident #1 was cognitively impaired, could make self understood and understood others. Further review documented the resident was totally dependent and required 1 person assistance for personal hygiene and bathing. Medical record review of the Quarterly MDS dated 5/10/15 documented Resident #1 was severely cognitively impaired, usually could make self understood and usually understood others. Further review documented the resident remained totally dependent with 1 person assistance for transfers and bathing. Medical record review of the care plan with the original date of 11/10/14, with an updated goal date of 5/5/15, documented Resident #1 had "...Impaired Activities of Daily Living (ADL), At risk for further decline/Requires assistance..." Further review documented the interventions of "...follow schedule for showers and bed baths weekly...Assistance required with transfers, toileting...bed mobility, and personal	F 312	F312 continued Her care plan has been changed to reflect that. Her bath schedule was reviewed with nursing staff providing care. Staff were instructed that if resident refused bathing care or if bathing is unable to be given that they must inform charge nurse or supervisors to arrange for alternate schedule. Resident #15 toileting needs were discussed with Activity staff member in question to assure that she followed up with nursing staff assigned resident's care for getting her toileted. All staff have been instructed to seek nursing staff when toileting needs are mentioned by residents. Bathing needs for resident were changed to bathing room that can accommodate a bathing stretcher, if bathing is choice of bathing. Staff have been instructed to notify Nurse Management when such issues arise. Resident #17 get up schedule and grooming time have been reviewed with her. Social Services is working with resident to establish a time that can best meet her expectations that does not conflict with breakfast for all residents. Method of Correction for all residents Staffing levels are reviewed daily with Nurse Management and Administrator to ensure resident needs can be met. Weekly,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 36 hygiene...Report refusals to nurse..." Review of the medical record revealed Resident #1 was in room 123 A prior to 5/22/15 and changed to room 120 B after 5/22/15. Review of the Shower/Bath Schedule revealed room 123 A was scheduled for Tuesday, Thursday and Saturday at 7:00 AM-3:00 PM and room 120 B was scheduled for Tuesday, Thursday and Saturday at 3:00 PM-11:00 PM. Review of the ADL Flow Log documented Resident #1 received a shower 4 out of of 14 opportunities in January 2015; 5 out of 12 opportunities in February 2015, 4 out of 13 opportunities in March 2015, 0 out of 13 opportunities in April 2015, 1 out of 13 opportunities in May 2015, and 1 out of 6 opportunities from June 1 - 15, 2015. Interview with Licensed Practical Nurse (LPN) #13 on 6/9/15 at 2:12 PM at the 1 East nurses station when asked why Resident #1 had not received a shower in 2 months stated, "I didn't know she hasn't had a shower at all...techs [Certified Nurse Aides] usually tell me when [resident] refuses." Interview with the Director of Nursing (DON) on 6/15/15 at 3:20 PM and 6/16/15 at 1:00 PM in the pharmacy room when asked if Resident #1 received showers per the Shower/Bath Schedule confirmed, "...no shower had been provided 3 times a week as scheduled..." Medical record review revealed Resident #4 was admitted to the facility on 4/9/13 with diagnoses including Congestive Heart Failure, Alzheimer's	F 312	F312 continued Administration and Nurse Management to review staffing needs for prior week and forecast needs for upcoming week to ensure that adequate staffing levels are maintained. The facility has contracted with agency services to supplement openings in nursing schedules. Additionally the facility has marketed on several online sites as well as added a link to their website for employment. A new wage structure has been developed to ensure rates are competitive along with a bonus program encouraging current employees to refer friends. Facility changed individual to manage the staffing. Staff schedules have been modified to provide more even coverage seven days a week. Orientation to be reassessed to focus on staff retention needs. Task force of Management and some CNT staff to work on evaluation of and updating of orientation. Staff education to be presented as per prior F282 tag to address toileting, dignity, meal assistance needs. All education will be documented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 37 Disease with Dementia, Depression, Aphasia, Muscle Weakness, and Seizures. Medical record review of a Quarterly MDS dated 12/21/14 documented the resident had moderated cognitive impairment. Continued review documented the resident required extensive assistance of 1 person for hygiene and dressing and total assistance of 1 person for bathing. Observation on 6/16/15 at 9:25 AM, revealed Resident #4 was in her room, dressed in a hospital type gown and seated in a wheelchair. Continued observation revealed the resident removed articles of clothing from the dresser drawers. Observation and interview with the resident on 6/16/15 at 11:04 AM, revealed the resident remained in her room, dressed in a gown. When asked if she was waiting on someone to assist her with getting dressed, the resident responded "Yes" and became tearful and upset. When the resident was asked if she had used the nurse call light to request help, she pointed at the light switch on the wall. When asked if she wanted the surveyor to activate her call light she nodded her head "Yes." The surveyor activated the call light. Observation on 6/16/15 at 11:06 AM, revealed CNA #11 responded to Resident #4's call light, entered the resident's room and closed the door. Medical record review revealed Resident #8 was admitted to the facility on 12/12/12 with diagnoses including Aftercare of Right Hip Fracture, Dysphagia, Dementia, Brain Mass, and Aortic	F 312	F312 continued QAPI and monitoring Nurse Administration and Administrator to review staffing schedules to review posted staffing schedules daily Monday through Friday and telephonically with weekend nurse leadership to assure for staffing needs to be met for resident requirements. MDS information found in the CMS672 and 802 forms on resident assistance needs will be utilized weekly to assure that staffing level meets the care needs of resident population. Administrator and MDS nurse will provide a forecast of resident needs for ADLs based on census at designated day of each week to present to the Nurse Administration in their scheduling. Daily staffing sheets have been modified to assure daily monitoring by Nurse Management /Administration. NHPPD goal is 2.85 or higher. At the weekly review, prior week's staffing sheets will be reviewed to see if compliance of 85% is met. Reviews will also reflect resident care audits of bathing and toileting needs. Measurements will include compliance on the NHPPD numbers as well as compliance of bathing and toileting non compliance decreasing. Findings will be reviewed at QAPI meeting with compliance reported and discussed for additional needs or modifications.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 38 Stenosis. Medical record review of a Quarterly MDS dated 12/14/14 documented Resident #8 was severely cognitively impaired. Continued review documented the resident was non-ambulatory, was totally dependent for hygiene, and was always incontinent of bowel and bladder. Medical record review of the care plan dated 10/2014 and updated 3/21/15 documented resident was incontinent of bowel and bladder. Continued review documented the goal was, "Resident will be kept clean and dry thru next review date", and interventions included "...provide incontinent care and change briefs as needed..." Further review of the care plan documented the resident was at risk for skin impairment due to incontinence with a goal of "...keep clean and dry..." and interventions "...check frequently for episodes of incontinence..." Observation of Resident #8 on 6/15/15 at 7:40-8:39 AM, revealed the resident was in the 1st floor dining room for breakfast. Further observation at 9:00 AM, revealed the resident was seated in a geriatric chair in the hall across from the 1 West nurses station. Further observation at 10:45 AM, revealed the resident seated in the geriatric chair in the dining room during an activity. Continued observation of the resident revealed she remained in the dining room at 11:50 AM. Further observation revealed the resident was in the dining room until 1:10 PM, at which time she was observed transported to the hall across from the 1 West nurses station. Further observation at 2:30 PM, revealed the resident was in the dining room for activities.	F 312	F312 continued Completion Date Agency contracts set up **06/12/15** New wage structure **06/30/15** Nursing Education on compliance of bathing needs for all residents **07/18/15** Staffing needs audit using CMS 672 and 802 **07/16/15** Administration/Nurse Management daily staffing reviews **6/19/15** Orientation task force reviews and update of orientation **07/21/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 39 Further observation revealed the resident remained in the dining room at 4:15 PM. Interview with Certified Nurse Aide (CNA) #15 on 6/15/15 at 4:45 PM, in the hall outside room 115, revealed she had come on duty at 3:00 PM. Stated she had not yet checked Resident #8 for incontinence. Continued interview revealed the resident would remain in the dining room through supper and after that she would sit in the hall until she was ready for bed. Continued interview revealed the resident would be checked for incontinence and changed when she was put to be. Continued interview revealed the resident had last been checked for incontinence by the staff on the previous shift who had been assigned to the resident's care. Interview with LPN #6 on 6/16/15 at 7:20 AM, in the 1 East Hall, revealed he had been assigned to care for Resident #8 on the 7AM to 3PM shift on 6/15/15. Continued interview revealed the resident was checked for incontinence once on the morning of 6/15/15 and at no other time during his shift. Continued interview confirmed the resident had not been adequately provided incontinence care. Interview and observation with CNA #1 on 6/16/15 at 11:18 AM in the resident's room, revealed she was assigned to the resident's care this date. Continued interview revealed the resident was out of bed and seated in a geriatric chair before she came on duty at 7:00 AM. Continued interview revealed the resident had not been checked for incontinence over the past 4 hours. CNA #1 was then asked to check the resident for incontinence. Observation revealed CNA #1 transferred Resident #8 to the bed.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 40	F 312		

Continued observation revealed the resident's incontinent brief was wet from urine. Interview with CNA #1 at 11:21 AM confirmed the facility had failed to provide incontinent care for the resident in a timely manner.
Interview with CNA #11 on 6/16/15 at 1:30 PM, in the first floor hallway by the elevators, revealed she had assisted the resident with personal care and dressing when she responded to the resident's call light earlier in the day. Continued interview confirmed the resident had not received assistance with bathing and dressing after breakfast as per her preference.

Medical record review revealed Resident #10 was admitted to the facility on 12/10/13 with diagnoses including Cerebrovascular Accident, Dysphagia, Muscle Weakness, Incoordination, Joint Contracture, and Dementia.

Medical record review of a Quarterly MDS dated 3/3/15 documented Resident #10 had moderate cognitive impairment, required set-up help and supervision for eating and had range of motion impairment of one upper and lower extremity (left side).

Medical record review of a care plan dated 12/15/14 documented "...at nutritional risk r/t [related to] dementia...interventions...red napkin program...encourage to eat 75-100% of meals daily..."

Observation of Resident #10 on 6/3/15 at 12:56 PM in the 2nd floor dining room revealed the resident was seated in a wheelchair at a table with 7 other residents. Continued observation revealed 3 staff were seated with their backs to the 7 residents and were assisting other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 41	F 312		

residents. Continued observation revealed Resident #10 took an unpeeled banana with her right hand and used her teeth to open the banana and unpeeled it, then started eating. Continued observation at 1:22 PM revealed Resident #10 had eaten a banana and a few bites of food on plate and self-propelled out of the dining room and staff did not encourage her to continue eating her meal.

Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room when asked if there was enough facility staff to meet the required care and services for the residents, the DON stated, "...I can't say that we've met everyone's needs..."

Medical record review revealed Resident #11 was admitted to the facility on 6/5/14 with diagnoses including Dementia with Behavioral Disturbances, History of Falls, Dysphagia, Muscle Weakness, Depression, Congestive Heart Failure and Diabetes Mellitus.

Medical record review of a Quarterly MDS dated 3/10/15 documented Resident #11 was severely cognitively impaired and required total assistance of 1 person for bathing.

Medical record review of an ADL Flow Sheet Log dated 5/1 - 31/15 documented Resident #11 had received 4 showers that month.

Observation of Resident #11 on 6/15/15 at 8:47 AM revealed the resident was seated in a geriatric chair, eyes closed and her hair was uncombed.

Observation of Resident #11 on 6/15/15 at 2:15 PM and at 4:22 PM revealed resident seated in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 42 geriatric chair, facing the 2nd floor dining room doorway. Continued observation revealed the resident had dried food and stains on her top and pants, and her hair was uncombed. Interview with CNA #3 on 6/15/15 at 2:45 PM in hallway near room 212, when asked if any of her assigned resident's had received their scheduled showers, CNA #3 stated, "...no...when we have 3 tech's [CNAs] there's no way you have time to...haven't given showers in a while..." When asked if Resident #11 has had a shower according to the schedule, CNA #3 stated, "...no...she's not..." When asked about residents assigned to her today, CNA #3 stated, "...have 14 residents...12 are total care...try to check and change at least once a shift...try to do twice if possible..." Observation of Resident #11 on 6/15/15 at 4:39 PM, after the surveyor requested CNA #16 to check resident for incontinence, the resident was taken to her room, and placed on the bed. Continued observation revealed the resident's brief was wet with urine and contained a small amount of feces, and the resident's buttocks and perianal area was red. Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room when asked if there was enough facility staff to meet the required care and services for the residents, the DON stated, "...I can't say that we've met everyone's needs..." Medical record review revealed Resident #13 was admitted to the facility on 8/25/11 with diagnoses including Dementia, Dysphagia, Osteoporosis, Psychosis, and Muscle Weakness.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 43 Medical record review of a Quarterly MDS dated 4/4/15 documented Resident #13 had severe cognitive impairment and required total assistance of 1 for bathing. Medical record review of an ADL Flow Sheet Log dated 5/1 - 31/15 documented Resident #13 had received 2 showers that month. Interview with CNA #2 on 6/15/15 at 2:45 PM on the 2nd floor near West nurses station, when asked if her assigned residents received their showers according to the schedule, stated, "...no...not enough time to do showers..." Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room when asked if there was enough facility staff to meet the required care and services for the residents, the DON stated, "...I can't say that we've met everyone's needs..." Medical record review revealed Resident #14 was admitted to the facility on 8/6/14 with diagnoses including Alzheimer's, Dementia with Behaviors, Gait Difficulties, Muscle Weakness and Depression. Review of the undated facility policy titled "Maintaining ADL Skills" revealed "...The facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of the resident..." Review of the Quarterly MDS dated 2/15/15 documented the resident was severely cognitively impaired and required extensive assistance from 1 person for hygiene and bathing. She required	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 44 extensive assistance from 2 people for transfers and assistance from 1 person for eating. Observation on 6/3/15 at 7:53 AM in the resident's room revealed the resident was sitting in her wheelchair (WC) with a pureed breakfast tray sitting on the over the bed table in front of her. The resident had a red napkin which designated the resident needed additional assistance with meals and observation. There was no staff present to coach or cue the resident. Continued observation revealed the resident was trying to drink from an unopened carton of orange juice. Further observation at 8:09 AM revealed the resident had not eaten anything, the orange juice was still unopened, she was not eating, and no one was assisting the resident. Observation on 6/8/15 at 8:35 AM in the resident's room revealed the resident was in the bed, her pureed breakfast tray was on the over the bed table in front of her. The resident's head was lying against the right upper side rail. Milk was spilled on the food and on the tray. The resident was patting the food with her hands. There was food and pepper on her gown, both hands, and forearms. The resident held out her hands and stated, "please help me, it hurts, it feels like it's going to crack, please help me, go get somebody, tell them I said." Continued observation revealed LPN #12 walked past the resident's room at 8:38 AM. CNA #10 looked into the room and kept on walking down the hall at 8:42 AM. CNA #5 entered the room at 8:48 AM and removed the uneaten breakfast tray. Interview with CNA #13 on 6/9/15 at 1:35 PM in the 1 West nurses station confirmed staffing was a problem and stated she had to tell	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 45	F 312		

resident's,"'I'll get to you in a minute,' because you were supposed to answer the call lights within 1-2 minutes." The CNA stated, "70% (percent) of the time the resident's needs are met with feeding and cueing...all shifts have deficiencies, but night shift gets the brunt of it...when night shift suffers, it throws everybody off... "

Observation on 6/10/15 at 8:07 AM in the 1st floor dining room revealed Resident #14 was 1 of 7 residents requiring feeding assistance and or cueing/coaching assistance. CNA #5 was the only staff member present in the dining room, and was assisting another resident. Resident #14 was observed eating her pureed diet with her hands.

Review of the Shower/Bath Schedule revealed Resident #14 was to receive a shower/bath every Monday, Wednesday, Friday on the 3 PM to 11 PM shift.

Interview with CNA #5 on 6/10/15 at 2:40 PM in the pharmacy room confirmed Resident #14 was unable to push the call light to ask for assistance. CNA #5 confirmed when the resident was cued regularly, and eats in the dining room, the resident will eat most of her meal. The CNA confirmed the resident was not receiving a shower 3 times per week. The CNA stated she had 18 residents to care for on the 7 AM to 3 PM shift, and 16 of them were incontinent. The CNA stated, "I haven't even touched three or four of my residents, it's too much."

Interview with LPN #12 on 6/11/15 at 3:30 PM in the pharmacy room stated, "showers are not being done." The LPN also confirmed "...staffing is an issue...3 techs with 17 residents each [51

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 46	F 312		

total residents] is not enough...we are overwhelmed and the techs are worn out..." Continued interview with the LPN stated, "We do not have enough personnel to keep people safe."

Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room when asked if there was enough facility staff to meet the required care for the residents, the DON stated, "I can't say that we've met everyone's needs."

Medical record review revealed Resident #15 was admitted to the facility on 6/14/13with diagnoses including Dementia, Abnormal Posture, Hypertension, Oral Dysphagia, Hallucinations, Anxiety with Depression.

Review of the Annual MDS dated 6/3/15 documented the resident had short and long term memory impairment and required extensive assistance from 1 person for bed mobility and transfers. The resident was always incontinent of bladder and bowel.

Medical record review of the comprehensive care plan dated 6/3/15 documented a problem of "Impaired ADL's at risk for further decline" with interventions including, "...Follow schedule for showers...Staff to anticipate and meet all needs on a daily basis...Assistance required with transfers toileting dressing bed mobility, and personal hygiene..." Continued review documented another problem of Resident was Incontinent of Bowel and Bladder-Risk for recurrent UTI. Interventions included: Provide daily care for resident; Provide incontinent care as needed; Turn and reposition while in bed or in chair for comfort..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 47	F 312		

Observation of Resident #15 on 6/3/15 at 12:55 PM in the 1st floor dining room revealed the resident was seated in a reclining Geri-chair, and had just finished being assisted with her lunch by the Activities Director. Continued observation at 12:57 PM revealed the resident stated, "I have to go to the bathroom." The Activities Director stated, "You'll have to wait until a tech can take you." Continued observation revealed the Activities Director asked the Activities Assistant to take the resident to her room. The Activities Assistant was taking another resident out of the dining room and said she would when she returned. The Activities Assistant returned at 1:05 PM and pushed Resident #15 in the Geri-chair out of the dining room into the hallway beside the resident's room and left her sitting there. Continued observation revealed the resident was lying in the recliner with her eyes closed, and stated "take it off, it hurts." No one came to assist the resident. At 13:30 PM CNA #13 was asked by the survyor to check the resident for incontinence. The resident was moved into the room, placed on the bed, and was found to be incontinent of urine.

Interview with CNA #13 at 1:37 PM in room 110 A confirmed the resident was incontinent of urine and the facility failed to provide incontinence care to Resident #15.

Medical record review of the Bath/Shower schedule revealed Resident #15 was to receive a shower every Tuesday, Thursday and Saturday.

Interview with CNA #10 on 6/10/15 at 2:40 PM in the pharmacy room confirmed that the resident was not capable of pushing the call light to ask for assistance. Continued interview revealed the resident was not receiving showers per the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 48 Bath/Shower schedule as the shower room was too small to accommodate a shower stretcher, and the resident could not tolerate sitting upright on the shower chair. Interview with LPN #12 on 6/11/15 at 3:30 PM in the pharmacy room confirmed "showers are not being done" as scheduled. Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room when asked if there was enough facility staff to meet the required care for the residents the DON stated, "I can't say that we've met everyone's needs." Medical record review revealed Resident #17 was admitted to the facility on 1/31/08 with diagnoses including History of a Cerebral Vascular Accident resulting in Left Sided Hemiplegia, Chronic Cervical Pain, Chronic Obstructive Pulmonary Disease, Diabetes, and Anxiety. Review of the Quarterly MDS dated 4/12/15 documented the resident was cognitively intact, and required extensive assistance from 1 person for bed mobility, transfers, dressing, toileting and personal hygiene. The resident was totally dependent for bathing, occasionally incontinent of urine and always continent of bowel. Medical record review of the comprehensive care plan dated 10/13/14 revealed a problem of "...At Risk for Further Decline/Requires Extensive Assistance..." Interventions included: Assist resident to get up before 10:00 AM as she desires; Allow to make decisions and be as involved with care concerns and schedules as able; Staff to anticipate and meet all needs on a daily basis; Assistance required with transfers,	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 49 toileting, dressing bed mobility, and personal hygiene; Encourage to use call light for needs. Interview with the resident on 6/9/15 at 12:55 PM in the 1st floor dining room revealed the resident had not been assisted out of bed, dressed, or toileted until 12:30 PM. The resident stated her normal routine was to be up, bathed, and dressed by 7:00 or 7:30 AM. Continued interview revealed the resident had pushed her call light 3 different times to ask for assistance to get up out of bed and to be assisted to the bathroom. Continued interview revealed even after the resident had told the LPN she needed to go to the bathroom and later that she was wet, no assistance was provided. The resident became incontinent of urine and had to lie in her saturated bed for 5 hours before being attended to. Interview with LPN #6 on 6/9/15 at 1:50 PM in the 1 West nurses station confirmed he was working as a CNA. The LPN stated, " The residents want to be up by 7:00 AM, and nights are supposed to get them up but there isn't enough staff." Continued interview confirmed the LPN did answer the call light for Resident #17 on 3 different times that day and did not provide assistance with transfers and toileting, and failed to provide bathing or dressing to Resident #17 after the resident explained she had become incontinent. Interview with CNA #5 on 6/10/15 at 2:40 PM in the pharmacy room confirmed Resident #17 was alert and normally continent of urine. The CNA stated,"the only reason she was wet and not up until 12:30 [PM] was cause staff couldn't get to her, cause we're always so short [staffed]..."	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 50 Interview with Resident #17 on 6/11/15 at 11:00 AM in the resident's room confirmed she had to lie in urine for 5 hours on 6/9/15. The resident stated, "I don't like peeing on myself. I like to be up at 7:00 [AM] not 12:30 [PM]...I just had to lay there wet and I hate it...made me feel pitiful, awful, and I hate it..." Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room when asked if there was enoughfacililty staff to meet the required care for the residents the DON stated, "I can't say that we've met everyone's needs. The facility was cited at a Substandard Quality of Care for the failure to provide adequate staffing to provide residents with the Activities of Daily Living, bathing, incontinence care and feeding, necessary in order to meet the resident's needs.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on review of the "National Pressure Ulcer Advisory Panel (NAUAP) Pressure Ulcer Prevention" quick reference guide, medical	F 314	F314 The facility will assure that a resident who enters facility without a pressure ulcer does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. Corrective Action Resident #12 was being evaluated by outside Wound clinic and a wound management group contracted by the facility. Weekly skin assessment was not available is now completed weekly. Method of Correction for all Residents Weekly skin assessments have been assigned to the 11-7 shift nurses to complete. Nurses will report off assessments completed to Nurse Management for current audit conducted weekly using resident roster for checking off completed skin assessments. List will be checked on Fridays to assure completeness and any assessments not done, will be completed before weekend. Any new skin issues will be reported immediately to nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 51 record review and interview, the facility failed to monitor and evaluate wounds, and document findings weekly for 1 (Resident #12) of 17 residents reviewed. The findings included: Review of the "NAUAP Pressure Ulcer Prevention" quick reference guide revealed "...weekly assessments provide an opportunity for the health professional to assess the ulcer more regularly, detect complications as early as possible, and adjust the treatment plan accordingly..." Medical record review revealed Resident #12 was admitted to the facility on 7/2/09 with diagnoses including Right Knee Infection, Joint Stiffness, Dysphagia, Dementia, Hypertension, and Pressure Ulcer Right Heel. Medical record review of an Annual Minimum Data Set dated 5/13/15 documented Resident #12 had severe cognitive impairment and required total assistance for Activities of Daily Living. Medical record review of Physician's Orders for 6/1 to 6/30/15 revealed Resident #12 had orders to treat right heel, coccyx, and left foot. Medical record review of Wound Care Assessments documented Resident #12's wounds were evaluated for measurement, exudate, wound bed, surrounding tissue, wound edges and staging on 4/5/15, 5/27/15, 6/1/15, and 6/15/15. Interview with the Director of Nursing on 6/16/15	F 314	F314 continued management for further assessment/treatment. Night nurses have been re-educated on weekly skin assessment protocol. QAPI and monitoring Nurse management or their designee will utilize a resident roster and check off each week completed skin assessments and provide a compliance report to DON. Compliance threshold will be 80% and reviewed at QAPI meeting for need of further evaluation/modification/ education. Nurses who are non compliant will be counseled and educated on their role in skin assessments. Completion Date Night nurses re-educated on weekly skin assessment protocol **6/22/15** Weekly audit of completion of skin assessments **7/16/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 52 at 1:40 PM in the 1st floor supervisor's office confirmed the facility had failed to complete a weekly assessment of the resident's wounds.	F 314		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure proper prosthetic care was provided for 1 (Resident #9) of 17 residents reviewed. The findings included: Medical record review revealed Resident #9 was admitted to the facility on 12/12/14 with diagnoses including Peripheral Vascular Disease, Bilateral Below the Knee Amputee, Muscle Weakness and Hypertension. Review of the 14 day Minimum Data Set (MDS) dated 1/15/15 documented the resident was cognitively intact and required extensive assistance from 2 people for transfers, and	F 328	F328 The facility will ensure that residents receive proper treatment and care for prostheses. Corrective Action With resident #9, CNA who assisted with placing prosthetics was counseled and educated on the need for physician orders and nursing instructions before application of individual prosthetics. Orders update and Licensed Therapist have instructed staff on proper application of prosthetics. Resident skin condition is monitored after each use and problems are reported to Licensed Nursing staff. Method of Correction for all Residents MDS nurse to review all MDS assessments for any other prosthetic devices in use and assure proper orders are in place. Nursing staff to be educated on need for complete understanding of orders for outside consulting doctors who prescribe prosthetic devices for residents and that residents use must be overseen by Licensed Physical Therapists un til protocol is established. QAPI and monitoring All residents who have prosthetic devices prescribed will be audited by Therapy group contracted by facility to assure that nurses	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 53 assistance from 1 person for personal hygiene. The resident was totally dependent requiring assistance from 1 person for bathing and toileting. Observation and interview of Resident #9 on 6/16/15 at 8:00 AM in the resident's room revealed the resident's prosthetics were sitting in the corner of the room. The resident had a dressing on her left stump dated 6/15/15. The resident stated she had a blister. Continued interview revealed the resident had gone to the doctor on 6/11/15 and received her new prosthetics. Continued interview revealed the resident was told she was to sit in a WC (wheelchair) with her prosthetics on and wheel herself around using her"new legs" for 1 hour each day to build up muscle strength. The resident stated a CNA helped her put the prosthestics on Friday, 6/12/15, and she sat in the WC. Continued interview revealed the resident did not receive assistance over the weekend using the prosthetics or sitting in the WC because on Sunday, 6/14/15, a blister appeared. Medical record review of the Physician/Prescribers orders revealed there were no orders for prosthetic use or therapy for the resident. Interview with LPN #2 on 6/16/15 at 8:20 AM in the 1 East nurses station confirmed there were no orders for prosthetic use or therapy for Resident #9. Continued interview confirmed there were no transfer orders, notes or any documentation received from the resident's physician after the resident returned from the appointment on 6/11/15.	F 328	and CNT staff who provide care for resident have been checked off on their understanding of the use and application of the prosthetic devices. Signed teaching acknowledgment will be kept in Resident's chart. Rehab program manager to monitor for compliance in documented education with audit showing resident name/prosthetic order/date of order/ proper orders in chart/ documented education of Nursing staff. Completion Date Review of MDS assessments for use of other prosthetic devices **07/08/05** Audit tool utilized **07/10/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 54 Interview with the Therapy Director on 6/16/15 at 8:30 AM in the 1 East nurses station revealed she had spoken with the Orthotist (healthcare professional skilled in making and fitting orthopedic appliances) on Friday (6/12/15) to notify him there were no physician orders for therapy for Resident #9. Continued interview revealed the Therapy Director was told by the Orthotist that he had contacted the physician's assistant on Friday 6/12/15 and had been told the orders were being faxed to the facility that same day. Continued interview revealed the Therapy Director stated, "I told him I was not comfortable providing therapy when no one had come to train the staff how to place, maintain, and care for this type of prosthetic." Continued interview revealed The Orthotist stated he would come on Monday or Tuesday (6/15 or 6/16/15) to instruct the staff, and he had shown the resident 4 times how to put on the prosthetics and observed the resident using correct technique. Continued interview revealed the Therapy Director stated she had "...talked it over with [LPN #13] and we decided to proceed with allowing the resident to place the prosthetics herself and sit in the WC for 1 hour a day..." Continued interview confirmed the Therapy Director was aware no physician orders had been received by 6/16/15. Interview with LPN #2 on 6/16/15 at 10:00 AM in the 1 East nurses station confirmed the facility had not yet received orders from the physicians office for Resident #9 and a faxed request had been sent. Interview with the Orthotist in the Therapy Director's office on 6/16/15 at 11:35 AM confirmed the resident had a blister on the left	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 55 stump and was not able to use the prosthetics for therapy at this time.	F 328		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on facility policy review, review of the Shower/Bath schedule, observation, medical record review, interview, and review of the ADL (Activities of Daily Living) Log, the facility failed to provide sufficient nursing staff to ensure the ADL's were provided for bathing, dressing, toileting and eating for 9 (Resident #4, 7, 8, 10, 11, 13, 14, 15, 17) of 17 residents reviewed.	F 353	F353 The facility will have sufficient nursing staff to provide nursing related services to attain or maintain the highest practicable physical, mental, and psycho-social well being. Corrective Action Residents 4/7/8/10/11/13/14/15/17 care issues were addressed with respective nursing staff on each floor. Method of Correction for all Residents Meal Service education to be conducted with all nursing staff. Nurse Management and Administration to round on each floor daily and care staff (LPN and CNT) are to report to Nurse Management or designee and /or Administrator when care cannot be completed. Any concerns noted by Management will involve staff counseling/education on the spot. Residents in needed of dining assistance will be re-evaluated by the Risk Committee and information shared with respective nursing stations to assure proper assistance is being offered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 56 The findings included: Review of the facility Red Napkin Protocol, with the revision date of 5/27/15, revealed "...Residents determined to have significant and/or potential problem with weight loss/eating/nutrition/...will be placed on the Red Napkin Program..." Further review revealed "...A red napkin will designate resident at risk and will serve as a visual reminder to staff...to provide over-site and monitoring during meals...To cue/assist/remind resident to eat each meal...Offer substitution when food is not being eaten..." Review of the undated facility policy "Feeding the Impaired Resident" revealed "...Residents are assisted, as needed, to consume each meal so adequate nutrition is provided." Further review revealed the "...Arrange dishes and silverware so the resident can reach them easily...Open all cartons and give napkin to the resident...Feed slowly...Alternate foods and liquids, as desired and needed...Alternate foods...or supplements, should be offered...if the resident consumes less than half the meal...Clean the resident's mouth and hands when the meal is finished...Record the percentage (%) of food consumption, as 25%, 50%, 75%, or 100%..." Review of the undated facility policy "Bath/Shower" revealed "...each resident shall be kept clean routinely through the use [of] bed bathing or shower. Residents will have a bath/shower at least 2 times a week. Resident's choices will be taken into consideration as to what time of day and the day of the week that	F 353	F353 continued Each resident's bathing schedule will be reviewed with the resident (if cognitively able) to assure bathing needs are met as needed/desired. Administrator to assign task force members to interview residents, when possible and families when needed regarding bathing preferences. Results will be shared with MDS nurse to reflect any changes needed for Care plan and MDS nurse will update staff on any modifications necessary for providing bathing care. Modifications will be made at least quarterly in conjunction with MDS assessments. Nurse Management will adjust bathing schedules posted at nurses stations and in the Care Tracker computers and communicate and educate CNT staff on complying with the bathing schedules for residents and the protocol for documenting correctly, dealing with refusals and reporting concerns to charge nurse. All education will be documented. Staffing levels are reviewed daily with Nurse Management and Administrator to ensure resident needs can be met. Weekly, Administration and Nurse Management will review staffing needs for prior week and forecast needs for upcoming week to ensure that adequate staffing levels are maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 57 they would prefer...Refusals of bath/shower should be reported to their charge nurse. Continued refusals of bath/shower will be reported to family..." Review of the facility Shower/Bath schedule revealed the shower/bath was assigned according the the resident's room number. Further review revealed no showers were scheduled for Sundays. Review of the facility policy "Resident Call Lights" revealed "...It is the policy...for all employees to assist in the answering of call lights in a timely manner..." Further review revealed "...Staff to be alerted when the call lights sound...and work to respond within 5-7 minutes whenever possible. If a staff member who responds is not a nursing personnel and the request is nursing related, it is the staff member's responsibility to find a nursing personnel to answer the concern and follow up to assure situation is handled, when possible...Whenever CNT [Certified Nurse Technician/Aide] staff go on break, they must inform their Charge Nurse or another staff member on that hall to assure that their call lights can be answered..." Observation during the initial tour on 6/3/15 at 5:15 AM, on the 2nd floor, revealed staffing posted on a dry erase board for current shift to include 1 Licensed Practical Nurse (LPN) and 1 Certified Nurse Aide (CNA) for a census of 42 residents. Interview with LPN #9 on 6/3/15 at 6:45 AM at the 2 West nurses station, when asked if staffing with 1 LPN and 1 CNA was sufficient for a census of 42 stated, "...no...we used to have more staff...no	F 353	F353 continued The facility has contracted with agency services to supplement openings in nursing schedules. Additionally the facility has marketed on several online sites as well as added a link to their website for employment. A new wage structure has been developed to ensure rates are competitive along with a bonus program encouraging current employees to refer friends. Facility changed individual to manage the staffing. Staff schedules have been modified to provide more even coverage seven days a week. Orientation to be reassessed to focus on staff retention needs. Task force of Management and some CNT staff will conduct evaluation of and updating of orientation. QAPI and monitoring Nurse Administration and Administrator to review staffing schedules to review posted staffing schedules daily Monday through Friday and telephonically with weekend nurse leadership to assure for staffing needs to be met for resident requirements. MDS information found in the CMS672 and 802 forms on resident assistance needs will be utilized weekly to assure that staffing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 58 one to call extra...would be afraid if there was an emergency..." Observation on 6/3/15 at 12:40 PM in the 2nd floor dining room revealed 17 residents with 3 staff providing total feeding assistance to 5 residents, who were all seated at 2 feeding tables to the left of the room. The 3 staff members had their backs to the other 12 residents in the dining room. 7 of the 12 residents were seated at a large rectangle table to the right of the room. Of those 7, 1 was drinking milk but not eating the food, and 1 was only eating the bread. Observation revealed the 3 staff members were not providing feeding assistance to the 7 residents in the dining room. Medical record review revealed Resident #4 was admitted to the facility on 4/9/13 with diagnoses including Congestive Heart Failure, Alzheimer's Disease with Dementia, Depression, Aphasia, Muscle Weakness, and Seizures. Medical record review of a Quarterly Minimum Data Set (MDS) dated 12/21/14 documented had moderate cognitive impairment. Continued review documented the resident required extensive assistance of 1 person for hygiene and dressing. Interview with LPN #12 on 6/11/15 at 3:56 PM in the pharmacy room revealed the resident preferred to get dressed after breakfast. Observation on 6/16/15 at 9:25 AM, revealed Resident #4 in her room, dressed in a hospital type gown and seated in a wheelchair. Observation and interview with the resident on 6/16/15 at 11:04 AM, revealed the resident	F 353	F353 continued level meets the care needs of resident population. Administrator and MDS nurse will provide a forecast of resident needs for ADLs based on census at designated day of each week to present to the Nurse Administration in their scheduling. Daily staffing sheets have been modified to assure daily monitoring by Nurse Management /Administration. NHPPD goal is 2.85 or higher. At the weekly review, prior week's staffing sheets will be reviewed to see if compliance of 85% is met. Findings will be reviewed at QAPI meeting with compliance reported and discussed for additional needs or modifications. Completion Date Nursing education on Red Napkin program and meal service protocol **07/13/15** Nursing Education on compliance of bathing needs for all residents **07/18/15** Agency contracts set up **06/12/15** New wage structure **06/30/15** Staffing needs audit using CMS 672 and 802 **07/16/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 59	F 353		

remained in her room, dressed in a gown. When asked if she was waiting on someone to assist her with getting dressed, the resident responded "Yes" and became tearful and upset. When the resident was asked if she had used the nurse call light to request assistance, she pointed to the light switch on the wall. When asked if she wanted the surveyor to activate her call light, she nodded "Yes."

Observation on 6/16/15 at 11:06 AM, revealed CNA #11 responded to Resident #4's call light, activated by the surveyor per the resident's request, entered the resident's room and closed the door.

Interview with CNA #11 on 6/16/15 at 1:30 PM, in the 1st floor by the elevators, revealed she had not been assigned to care for Resident #4 this date but she did answer the resident's call light earlier in the day. Continued interview stated she had assisted the resident with personal care and dressing because her assigned CNA was too busy to assist the resident. Continued interview confirmed the resident had not received assistance with dressing in a timely manner.

Medical record review revealed Resident # 7 was admitted to the facility on 5/21/10 with diagnoses including Hypertension, Schizophrenia, Obesity, and Anxiety.

Medical record review of an Annual MDS dated 4/17/15 documented the resident was cognitively intact. Continued review documented the resident required extensive assistance with bathing and hygiene, and was always incontinent of bowel and bladder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 60	F 353		

Review of the facility shower schedule revealed the resident was to have a shower three times per week.

Medical record review of the ADL Flow Sheet Log for 5/1/15-6/6/15 revealed Resident # 7 had received a total of 8 showers from 5/1-24/15. Continued review revealed the resident had not received a shower from 5/25/15-6/6/15.

Interview with CNA #5 on 6/10/15 at 2:42 in the pharmacy room, revealed she was assigned to provide care for Resident #7 on this date. Continued interview revealed she had 18 residents assigned to her and 16 of those were incontinent. Continued interview revealed Resident #7 had been checked for incontinence once during her 7 AM - 3 PM shift.

Interview with CNA #1 on 6/15/15 at 2:00 PM, in the hallway outside room 112, revealed she was usually assigned to care for 13-17 residents on her shift. When asked if she felt she was able to provide adequate care for 13-17 residents, she stated "...when the facility is understaffed the residents don't get showers, and they don't always get checked [for incontinence] every two hours..."

Medical record review revealed Resident #8 was admitted to the facility on 12/12/12 with diagnoses including Aftercare of Right Hip Fracture, Dysphagia, Dementia, Brain Mass, and Aortic Stenosis.

Medical record review of a Quarterly MDS dated 12/14/14 documented Resident #8 was severely cognitively impaired. Continued review documented the resident was always incontinent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 61	F 353		

of bowel and bladder, and totally dependent for hygiene and bathing.

Observation of Resident #8 on 6/15/15 at 7:40-8:39 AM, revealed the resident was in the dining room for breakfast. Further observation at 9:00 AM, revealed the resident was seated in a geriatric chair in the hall across from the 1 West nurses station. Further observation at 10:45 AM, revealed the resident seated in the geriatric chair in the dining room during an activity. Continued observation of the resident revealed she remained in the dining room at 11:50 AM. Further observation revealed the resident was in the dining room until 1:10 PM, at which time she was observed transported to the hall across from the 1 West nurses station. Further observation at 2:30 PM, revealed the resident was in the dining room for activities. Further observation revealed the resident remained in the dining room at 4:15 PM.

Interview with CNA #15 on 6/15/15 at 4:45 PM, in the hall outside room 115, revealed she had come on duty at 3:00 PM. Stated she had not yet checked Resident #8 for incontinence. Continued interview revealed the resident would remain in the dining room through supper and after that she would sit in the hall until she was ready for bed. Continued interview revealed the resident would be checked for incontinence and changed when she was put to bed. Continued interview revealed the resident had last been checked for incontinence by the staff on the previous shift who had been assigned to the resident's care.

Interview with LPN #6 on 6/16/15 at 7:20 AM, in the 1 East Hall, revealed he had been assigned to care for Resident #8 on the 7AM to 3PM shift on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 62	F 353		

6/15/15. Continued interview revealed the resident was checked for incontinence once on the morning of 6/15/15 and at no other time during his shift. Continued interview revealed he didn't have time to check the resident again. Continued interview confirmed the resident had not been adequately provided incontinence care.

Interview and observation with CNA #1 on 6/16/15 at 11:18 AM in the resident's room, revealed she was assigned to the resident's care for the 7 AM -3 PM shift. Continued interview revealed the resident was out of bed and seated in a geriatric chair before she came on duty at 7:00 AM. Continued interview revealed the she had not had a "chance" to check the resident for incontinence over the past 4 hours. CNA #1 was then asked to check the resident for incontinence. Observation revealed CNA #1 transferred Resident #8 to the bed. Continued observation revealed the resident's incontinent brief was wet from urine.

Medical record review revealed Resident #10 was admitted to the facility on 12/10/13 with diagnoses including Cerebrovascular Accident, Dysphagia, Muscle Weakness, Incoordination, Joint Contracture, and Dementia.

Medical record review of a Quarterly MDS dated 3/3/15 documented Resident #10 had moderate cognitive impairment, required set-up help and supervision for eating; and had range of motion impairment of one upper and lower extremity (left side).

Observation of Resident #10 on 6/3/15 at 12:56 PM in the 2nd floor dining room revealed the resident took an unpeeled banana with her right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 63	F 353		

hand, used her teeth to open the banana and unpeeled it, and then started eating the banana. Continued observation revealed the staff failed to assist the resident with the meal.

Medical record review revealed Resident #11 was admitted to the facility on 6/5/14 with diagnoses including Dementia with Behavioral Disturbances, History of Falls, Dysphagia, Muscle Weakness, Depression, Congestive Heart Failure and Diabetes Mellitus.

Medical record review of a Quarterly MDS dated 3/10/15 documented Resident #11 was severely cognitively impaired and was total care for Activities of Daily Living.

Review of Meal Carts Time Period, updated 3/1/15, revealed the 2nd floor dining room meal trays were to be delivered at 12:00 PM.

Observation of Resident #11 on 6/3/15 in the 2nd floor dining room revealed the following:

12:40 PM (40 minutes after scheduled tray delivery to the dining room) - resident's tray had a red napkin, indicating she required assistance or cueing to eat.

1:13 PM (1 hour and 13 minutes after scheduled tray delivery to the dining room) - the resident's right hand was shaking as she took it and played in the food on her plate and never picked up eating utensils.

1:15 PM - resident was licking the food off the fingers of her right hand.

1:17 PM - the resident was observed making a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 64	F 353		

chewing motion on the side of her left thumb.

1:21 PM - the resident raised her left hand toward LPN #4, who was standing near the doorway on the right side of the room. LPN #4 stated "...yes?..." and Resident #11 had garbled speech and was looking at LPN #4. LPN #4 continued out the doorway and Resident #11 put her left thumb to the edge of her mouth and started a chewing motion.

1:26 PM - resident continued with chewing motion to the edge of left thumb. LPN #5 was observed standing while assisting the resident to eat dessert. At 1:30 PM LPN #5 was observed putting food on the spoon and handed it to the resident and the LPN walked away.

1:33 PM - the resident dropped the spoon and discontinued eating. CNA #2 approached the resident and stated, "...have you finished eating?..." and walked away.

1:35 PM (1 hour and 35 minutes after scheduled tray delivery to the dining room) - CNA #2 returned with a plastic spoon and attempted to feed a spoon of pureed white substance and Resident #11 turned head away. CNA #2 took the meal tray away.

Interview with Speech Therapist (ST) #1 on 6/10/15 at 10:35 AM in the therapy office, after describing Resident #11's behavior during meal time and making a chewing motion on her thumbs, stated, "...that's an infantile reflex...she may have been hungry..."

Medical record review revealed Resident #13 as admitted to the facility on 8/25/11 with diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 65 including Dementia, Dysphagia, Osteoporosis, Psychosis, and Muscle Weakness. Medical record review of a Quarterly MDS dated 4/4/15 documented Resident #13 had severe cognitive impairment and required total assistance of 1 person for eating. Review of Meal Cart Times documented the 2nd floor dining room cart was scheduled to be delivered to the floor at 7:55 AM. Observation on 6/4/15 at 9:15 AM (1 hour and 20 minutes after scheduled delivery to the floor), in the resident's room revealed CNA #6 set-up the meal tray and started to feed the resident. Interview with CNA #6 on 6/16/15 at 8:00 AM at 2 East nurses station stated, "...not enough staff to provide the care necessary...hard to bathe and feed everyone with just 3 techs...trays have to sit for those who require us to feed them..." Medical record review revealed Resident #14 was admitted to the facility on 8/6/14 with diagnoses including Alzheimer's, Dementia with Behaviors, Gait Difficulties, Muscle Weakness and Depression. Review of the Quarterly MDS dated 2/15/15 documented the resident was severely cognitively impaired and required limited assistance from 1 person for eating. Review of the undated facility policy titled "Maintaining ADL Skills" documented, "...The facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 66 the resident..." Observation on 6/3/15 at 7:53 AM in the resident's room revealed the resident was sitting in her wheelchair (WC) with a pureed breakfast tray sitting on the over the bed table in front of her. The resident had a red napkin which designated the resident needed additional assistance with meals and observation. There was no staff present to coach or cue the resident. Continued observation revealed the resident was trying to drink from an unopened carton of orange juice. Further observation at 8:09 AM revealed the resident had not eaten anything, the orange juice was still unopened, she was not eating, and no one was assisting the resident. Observation on 6/8/15 at 8:35 AM in the resident's room revealed the resident was in the bed, her pureed breakfast tray was on the over the bed table in front of her. The resident's head was lying against the right upper side rail. Milk was spilled on the food and on the tray. The resident was patting the food with her hands. There was food on her gown, and both hands, and pepper was on her hands and forearms. The resident held out her hands and said, "...please help me, it hurts, it feels like it's going to crack, please help me...go get somebody...tell them I said..." The resident was alone, and no one was assisting her. Continued observation revealed LPN #12 walked past the resident's room at 8:38 AM. CNA #10 looked into the room and kept on walking down the hall at 8:42 AM. CNA #5 entered the room at 8:48 AM and removed the uneaten breakfast tray. At 8:50 AM CNA's #5 and #10 entered the resident's room and shut the door.	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 67 Interview with CNA #13 on 6/9/15 at 1:35 PM in the 1 West nurses station confirmed staffing was a problem and stated, "...I've had to tell resident's "I'll get to you in a minute" because you were supposed to answer the call lights within 1-2 minutes..." The CNA stated, "...70% (percent) of the time the resident's needs are met with feeding and cueing...all shifts have deficiencies, but night shift gets the brunt of it...when night shift suffers, it throws everybody off... " Observation on 6/10/15 at 8:07 AM in the 1st floor dining room revealed Resident #14 was 1 of 7 residents requiring feeding assistance and or cueing/coaching assistance. CNA #5 was the only staff member present in the dining room, and was assisting another resident. Resident #14 was observed eating her pureed diet with her hands. Review of the Shower/ Bath Schedule revealed Resident #14 was to receive a shower or bath every Monday, Wednesday, Friday on the 3 PM to 11 PM shift. Interview with CNA #5 on 6/10/15 at 2:40 PM in the pharmacy room confirmed Resident #14 was unable to push the call light to ask for assistance. CNA #5 confirmed "...when the resident was cued regularly, and eats in the dining room, the resident will eat most of her meal..." The CNA confirmed the resident was not receiving a shower 3 times per week as scheduled. The CNA stated "...I have 18 residents to care for on the 7 AM to 3 PM shift...16 of them were incontinent...I haven't even touched three or four of my residents... it's too much..." Interview with LPN #12 on 6/11/15 at 3:30 PM in	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 68	F 353		

the pharmacy room stated, "...showers are not being done..." The LPN stated "...staffing is an issue...3 techs with 17 residents each [51 total residents] is not enough...we are overwhelmed and the techs are worn out..." Continued interview with the LPN stated, "...We do not have enough personnel to keep people safe..."

Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room, when asked if there was enough facility staff to meet the required care for the residents, the DON stated "...I can't say that we've met everyone's needs..."

Medical record review revealed Resident #15 was admitted to the facility on 6/14/13 with diagnoses including Dementia, Abnormal Posture, Hypertension, Oral Dysphagia, Hallucinations, Anxiety with Depression.

Review of the Annual MDS dated 6/9/14 documented the resident was severely cognitively impaired; required extensive assistance from 1 person for toileting; and required total assistance of 1 person for personal hygiene and bathing. Continued review revealed the resident was always incontinent of bladder and bowel.

Observation of Resident #15 on 6/3/15 at 12:55 PM in the 1st floor dining room revealed the resident was seated in a reclining Geri-chair, and had just finished being assisted with her lunch by the Activities Director. Continued observation at 12:57 PM revealed the resident stated, "I have to go to the bathroom." The Activities Director stated, You'll have to wait until a tech can take you." Continued observation revealed the Activities Director asked the Activities Assistant to take the resident to her room. The Activities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 69	F 353		

Assistant was taking another resident out of the dining room and said she would when she returned. The Activities Assistant returned at 1:05 PM and pushed Resident #15 in the geri-chair out of the dining room into the hallway beside the resident's room and left her sitting there. Continued observation revealed the resident was laying in the recliner with her eyes closed, and stated "take it off, it hurts." No one came to assist the resident. At 1:30 PM CNA #13 was asked by the surveyor to check the resident for incontinence. The resident was moved into the room, placed on the bed, and was found to be incontinent of urine.

Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room, when asked if there was enough facility staff to meet the required care for the residents, the DON stated "...I can't say that we've met everyone's needs..."

Medical record review of the Bath/Shower Schedule revealed Resident #15 was to receive a shower every Tuesday, Thursday and Saturday.

Interview with CNA #10 on 6/10/15 at 2:40 PM in the pharmacy room confirmed that the resident was not capable of pushing the call light to ask for assistance. Continued interview revealed the resident was not receiving showers per the shower schedule as the shower room was too small to accommodate a shower stretcher, and the resident cannot tolerate sitting upright on the shower chair.

Interview with LPN #12 on 6/11/15 at 3:30 PM in the pharmacy room stated, "...showers are not being done as scheduled..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 70 Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room, when asked if there was enough facility staff to meet the required care for the residents, the DON stated "...I can't say that we've met everyone's needs..." Medical record review revealed Resident #17 was admitted to the facility on 1/31/08 with diagnoses including History of a Cerebral Vascular Accident resulting in Left Sided Hemiplegia, Chronic Cervical Pain, Chronic Obstructive Pulmonary Disease, Diabetes, and Anxiety. Review of the Quarterly MDS dated 4/12/15 documented the resident was cognitively intact; required extensive assistance from 1 person for dressing, toileting and personal hygiene; required total assistance for bathing; and was occasionally incontinent of urine and always continent of bowel. Interview with the resident on 6/9/15 at 12:55 PM in the 1st floor dining room revealed the resident had not been assisted out of bed, dressed, or toileted until 12:30 PM. The resident revealed her normal routine was to be up, bathed, and dressed by 7:00 or 7:30 AM. Continued interview revealed the resident had pushed her call light 3 different times to ask for assistance to get up out of bed and to be assisted to the bathroom. Continued interview revealed even after the resident had told the LPN she needed to go to the bathroom and later that she was wet, no assistance was provided. The resident states she became incontinent of urine and had to lie in her saturated bed for 5 hours before staff came to assist her. Interview with LPN #6 on 6/9/15 at 1:50 PM in the 1 West nurses station confirmed he was working	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 71	F 353		

as a CNA. The LPN stated, " The residents want to be up by 7:00 AM, and nights are supposed to get them up but there isn't enough staff." Continued interview confirmed the LPN did answer the call light for Resident #17 on 3 different times that day and did not provide assistance with transfers and toileting, and failed to provide bathing or dressing after the resident explained she had become incontinent.

Interview with CNA #5 on 6/10/15 at 2:40 PM in the pharmacy room confirmed Resident #17 was alert and normally continent of urine. The CNA stated, "the only reason she was wet and not up until 12:30 [PM] was cause staff couldn't get to her, cause we're always so short [staffed]..."

Interview with Resident #17 on 6/11/15 at 11:00 AM in the resident's room confirmed she had to lie in urine for 5 hours on 6/9/15. The resident stated, "I don't like peeing on myself. I like to be up at 7:00 [AM] not 12:30 [PM]...I just had to lay there wet and I hate it...made me feel pitiful, awful, and I hate it..." Continued interview revealed the staff told the resident "we're short [staffed]..."

Interview with the DON on 6/16/15 at 2:00 PM in the pharmacy room, when asked if there was enough facility staff to meet the required care for the residents, the DON stated "...I can't say that we've met everyone's needs..."

Telephone interview with LPN #10 on 6/10/15 at 9:35 AM, when questioned about staffing and resident care, stated, "...Sunday night there was 4 nurses on 7P -7A, Monday there was 3 and Tuesday we had 2 on 7P-7A...staff is upset...patient care is lacking with the staff we

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 72 have..." Interview with Registered Nurse (RN) #1 on 6/15/15 at 8:32 AM in the 1st floor dining room, and 6/15/15 at 2:02 PM in the hall outside room 124, stated, over the weekend of 6/13-14/15, resident census of 95 and 94 respectively, due to call outs of staff on the 7:00 AM-7:00 PM shift, the needs of the residents could not be met with less than 4 CNA. The 1st floor had 2 CNA scheduled 7:00 AM-7:00 PM, 1 CNA 7:00 AM-3:00 PM, and 1 CNA was called in for 3:00 PM-7:00 PM. Interview stated, the evening LPN supervisor came in from 10:00 AM-2:00 PM to help CNA as did the Administrator from 9:00 AM-2:00 PM. Interview revealed, RN #1 had found residents wet and would tell the CNA but could not assist since "...1 West med pass is non-stop...". Interview stated, "...no way with 25-30 residents to give medications on time...have to start early..." Further interview stated, "...I can't feed residents on 1 West due to medication pass, may go in with medications, give a bite, give the medication and get them going with self feeding but have to leave to get medication pass done..."Further interview revealed, if had 3 CNA "...were lucky to get one ice pass in 12 hours [on weekends]..." Interview with CNA #2 on 6/15/15 at 2:45 PM in the break room on 2nd floor, when asked about assignment and checking and changing residents stated, "...I touch all of them once...would love to do all twice...not able to do showers with less than 4 techs [Certified Nurse Aides]..." Telephone interview with CNA #7 on 6/15/15 at 3:09 PM stated, "...there's not enough help to meet the resident's needs and if something	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 73 doesn't happen soon...I don't know what's going to happen..." Interview with CNA #16 on 6/15/15 at 4:05 PM on 2 East hallway, when asked about providing resident care stated, "...work 3PM to 11 PM...this past weekend was a nightmare...was able to get 2 rounds done, but the first round every resident was a mess...soiled..." When asked if able to do showers per schedule stated, "...no...group is overloaded...can't do all the showers..." When asked about toileting residents, CNA #16 stated, "...during meals the residents have to wait to go to the bathroom..."	F 353		
F 354 SS=D	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the facility Daily Staffing Assignment Sheets, and interview, the facility failed to had a Registered Nurse on site for 8 consecutive hours daily for 4 of 30 days in April	F 354	F354 The facility will use the services of a registered nurse for at least 8 consecutive hours a day, 7 days per week. Corrective Action Nurse Management reviewed schedule to assure the 8 hours of RN coverage occurs 7 days per week. Method of Correction for all residents Facility is actively recruiting for RN Supervisor for other shifts to provide more than 8 hours day coverage. Staffing levels are reviewed daily with Nurse Management and Administrator to ensure resident needs can be met. Weekly, Administration and Nurse Management will review staffing needs for prior week and forecast needs for upcoming week to ensure that adequate staffing levels are maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 354	Continued From page 74 2015. The findings included: Review of the 4/1-30/15 Daily Staffing Assignment Sheets documented the facility failed to have a Registered Nurse (RN) on site for 8 consecutive hours daily for 4/13, 21, 23, and 26/15 with a resident census of 96 and 98 respectively. Interview with the Director of Nursing (DON), on 6/9/15 at 1:10 PM, in the DON's office, and the Administrator at 1:18 PM, in the Administrator's office, confirmed, the facility failed to provide 8 consecutive hours of RN services for 4/13, 21, 23, and 26/15.	F 354	F354 continued QAPI and monitoring Administration and Nurse Management to review week's schedule in advance and audit for RN coverage of minimum of 8 hours each day. Monthly calendar will be maintained to document compliance. Compliance threshold is 100% and results will be reported at regular QAPI meetings to assess for any further interventions. Completion Date Review of week's schedule **06/09/15** Weekly meeting with Administration and Nurse Management to review schedule **06/21/15**	
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, test tray results, interview, medical record review, and review of the Meal Cart Time Period/Meal Cart Times forms, the facility failed to provide food that was palatable and at a proper temperature for 2 (Resident #2, 13) of 17 residents reviewed.. The findings included:	F 364	F364 Each resident will receive food prepared by methods that conserve nutritive value and food that is palatable, attractive and at proper temperature.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 75 Observation on 6/3/15 at 12:30 PM revealed the resident mid-day meal tray line was in process in the dietary department. Further observation and interview with the Certified Dietary Manager (CDM) confirmed the following temperatures, in degrees Fahrenheit (F), on the tray line: Spaghetti was 194.5 F; Meatsauce was 176.8; Cauliflower was 183.6 F; Pureed Spaghetti was 210.5 F; Pureed Meatsauce was 200 F; Pureed Cauliflower was 201 F; and Milk 40 F. Further observation revealed the last cart to the 1st floor contained a total of 13 trays, including the test tray, left the dietary department at 12:48 PM, arrived to the 1 West nurses station at 12:50 PM; first resident tray was delivered at 12:51 PM; the last resident tray was delivered at 1:22 PM; and the last resident was eating at 1:24 PM. Further observation and interview with the CDM on 6/3/15, at 1:25 PM, confirmed the following test tray temperatures in degrees F: Spaghetti with Meatsauce 117.6 F (a loss from 194.5 F/176.8 F); Cauliflower 105.4 F (a loss of 78.2 F); and Milk 53.7 F (an increase of 13.7 F). Further interview with the CDM, on 6/3/15 at 1:25 PM confirmed the Spaghetti with Meatsauce was not hot and the milk was not cold. Further interview stated "There are not enough hands to pass the food so food cooled down." Medical record review revealed Resident #2 was admitted to the facility on 12/27/12 with diagnoses including Acute Asthmatic Bronchitis,	F 364	F364 continued Corrective Action Staff on each floor were educated on the location of the microwave in each clean utility room and the importance of keeping hot food warm and cold food cool when serving residents. Staff were instructed to inquire with residents able to answer if food temperature was adequate if resident was not eating food served. Method of Correction for all Residents All food carts to be assessed for ability to hold heat and latches will be adjusted to reduce opportunity for heat loss. Nursing staff to be reminded to keep food cart doors closed when trays remain inside and to avoid serving resident trays unless a resident is in place to ready to eat. Milk service to be evaluated with storage in milk cooler at a lower temperature and not keeping milk on tray line in bulk. Seeking assistance from food service sales rep for options. Dietary staff will be educated on milk storage for cooler temps. Food Service Manager or designee will assess test tray food temps on the first and second floor hall carts at a minimum of three times per week (one breakfast, one lunch, one dinner). Food Service Manager or designee will randomly check trays in resident rooms for proper food	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 76 Cerebrovascular Accident, Obstructive Asthma, Hypertension, Anemia, Depression, and Anxiety. Medical record review of an Annual Minimum Data Set (MDS) dated 3/10/15 documented Resident #2 had moderate cognitive impairment and required total assistance of 1 person for eating. Review of the Meal Cart Time Period, updated 3/1/15, documented the 2nd floor hall cart was scheduled to be delivered to the floor at 12:20 PM. Observation and interview on 6/10/15 at 1:52 PM, 1 hour and 32 minutes after delivery of the trays to the unit, revealed CNA #3 in Resident #2's room, had set up the meal tray, and had started assisting the resident with the meal. When the resident was asked how lunch was he stated, "...it's cold..." When CNA #3 was asked if the tray had been reheated prior to delivery, the CNA looked at Resident #2 and stated, "...do you want me to heat it for you..." Medical record review revealed Resident #13 was admitted to the facility on 8/25/11 with diagnoses including Dementia, Dysphagia, Osteoporosis, Psychosis, and Muscle Weakness. Medical record review of a Quarterly MDS dated 4/4/15 documented Resident #13 had severe cognitive impairment and was total assistance of 1 person for eating. Review of the Meal Cart Times revealed the 2nd floor dining room cart was scheduled to be delivered to the floor at 7:55 AM.	F 364	F364 continued Nursing staff to be educated on the importance of keeping foods at right temperature to make them palatable. QAPI and monitoring Food Service manager or designee to use audit tool that records date/time tray leaves kitchen with temperature/time tray is tested from cart and temperature/ actions taken. Compliance will be reviewed weekly with threshold of 85%. Results and recommendations will be reported at regular QAPI meetings for further action. Food Service Manager will monitor. Nursing staff will be asked to record meals that are re-heated with a document posted at the microwave of each floor. The Record will have the following information recorded: resident name/ date/meal/time. Dietary Manager is responsible for maintaining the record and retrieving information weekly for review/action. This information will also be shared at the regular QAPI meeting for further need of interventions/education. Completion Date Food carts modified **7/10/15** Dietary staff educated on milk service storage **7/6/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 77 Observation on 6/4/15 at 9:15 AM, 1 hour and 20 minutes after delivery of the trays to the unit, in Resident #13's room revealed CNA #6 set-up the meal tray and start to feed the resident. Continued observation revealed CNA #6 placed a yellow substance on the spoon and asked the resident if she wanted some eggs. Resident #13 took a bite and then turned her head away. CNA #6 then placed a light brown substance on the spoon and asked the resident if she wanted some sausage. The resident took one small bite and said "...no..." CNA #6 stated "...let's try some oatmeal..." and placed oatmeal on the spoon and the resident ate it. Interview with CNA #6 on 6/4/15 at 3:02 PM in the hallway near room 234, when asked about Resident #13's meal intake for breakfast, stated, "...she ate only a few bites of oatmeal..." When asked if there was a microwave available to reheat the food, CNA #6 confirmed there was one in the clean utility room. When asked if he had reheated the meal tray prior to assisting the resident, CNA #6 stated, "...no...I didn't..."	F 364	Nursing staff educated on use of microwave for warming foods **7/15/15** Food temperature audits **7/14/15**	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to honor food preferences for 3 (Resident #9, 15, 17) of 17 residents reviewed.	F 365	F365 Each resident will receive food prepared in a form designed to meet individual needs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 365	Continued From page 78 The findings included: Medical record review revealed Resident #9 was admitted to the facility on 12/12/14 with diagnoses including Peripheral Vascular Disease, Bilateral Below the Knee Amputee, Muscle Weakness and Hypertension. Interview with Resident #9 on 6/4/15 at 9:22 AM in the resident's room when asked how the food was stated, "...the food is fair, and it's not hot. It's about 30 minutes from the kitchen until it gets down here..." Continued interview revealed the resident was still receiving food that she dislikes such as sandwiches and pork chops with barbeque sauce on them. The resident stated, "...I can't tolerate a heavy diet, nothing spicy, no sandwiches but they still bring it to me on occasion...I want buttermilk with my lunch and supper but they tell me they're all out..." Medical record review of the Dietary Progress Notes dated 2/4/15 revealed the dietician spoke with the resident's daughter by phone to obtain the resident's food preferences although the resident was cognitively intact. Review of the resident's meal card dated 6/11/15 documented dislikes were spicy food, sandwich, and the resident had hand written "salads" to be added to the list of dislikes. Medical record review revealed Resident #15 was admitted to the facility on 6/14/13 with diagnoses including Dementia, Hypertension, Oral Dysphagia, Hallucinations, Anxiety with Depression. Review of the Annual Minimum Data Set (MDS)	F 365	F365 continued Corrective Action Residents 9/15/17 had their food preferences reviewed with either the resident or their family and their diet cards were modified. Dietary staff who work on the tray line were re-educated on the importance of reviewing tray tickets for resident likes and dislikes as meals are being prepared. Education documented. Method of Correction for all Residents Dietary Manager or designees to review and update as needed all food preferences and make adjustment to tray tickets informing tray line staff when changes are made. Food preferences will be reviewed and updated at annual MDS/Care plan review or as needed. QAPI and monitoring Dietary Manager will utilize audit tool at tray line which measures compliance with tray accuracy. The audit includes date/time/meal served/resident name/ tray ticket served accurately. Compliance threshold will be 85% and results will be reported at regular QAPI meetings with need for further education or follow up. Completion date Residents 9/15/17 food preferences reviewed and updated **7/15/15** Dietary staff educated tray ticket accuracy **06/24/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 365	Continued From page 79 dated MDS 6/3/15 documented the resident had short and long term memory loss, was totally dependent and required assistance from 1 person for eating. Observation of Resident #15 on 6/3/15 at 12:55 PM in the first floor dining room revealed the resident was seated in a reclining geri-chair, and had just finished being assisted with her lunch by the Activities Director. The resident was served spaghetti, cauliflower, and chocolate cake and the resident's meal card indicated her dislikes as pasta and cauliflower. Medical record review revealed Resident #17 was admitted to the facility on 1/31/08 with diagnoses including History of a Cerebral Vascular Accident resulting in Left Sided Hemiplegia, Chronic Cervical Pain, Chronic Obstructive Pulmonary Disease, Diabetes, and Anxiety. Review of the Quarterly MDS dated 4/12/15 documented the resident was cognitively intact. Observation on 6/3/15 at 12:36 PM in the 1st floor dining room revealed Resident #17 had just finished her lunch and was propelling self out of the dining room in her electric wheelchair (WC). Observation of the meal card under "dislikes" was listed cauliflower. The resident had been served fish, bread, cauliflower and cake. All of the bread and cake had been eaten, half of the fish was eaten, and none of the cauliflower had been eaten. Interview with the resident on 6/3/15 at 12:37 PM in the doorway of the 1st floor dining room stated she was served "dislikes" regularly. The resident stated, "...You should just wait and see, I don't	F 365	F365 continued Tray ticket accuracy audits **7/10/15**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 365	Continued From page 80 want carrots either, but I get carrots every day..."	F 365		
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview, the facility failed to offer a food substitute to 1 (Resident #2) of 17 residents reviewed. The findings included: Review of an undated facility policy "Menu Substitutions", revealed "...appropriate and reasonable substitutions should be offered to accommodate know food habits, customs, and appetites of individual residents..." Medical record review revealed Resident #2 was admitted to the facility on 12/27/12 with diagnoses including Acute Asthmatic Bronchitis, Cerebrovascular Accident, Obstructive Asthma, Hypertension, Anemia, Obesity, Depression, and Anxiety. Medical record review of an Annual Minimum Data Set dated 3/10/15 documented Resident #2 had moderate cognitive impairment and required total assistance of 1 person for eating. Observation and interview on 6/3/15 at 8:55 AM in the resident's room revealed Resident #2 lying	F 366	F366 Each resident will receive substitutes offered of similar nutritive value to residents who refuse food served. Corrective Action Resident #2 was reminded that they can request a substitute if they do not like what is being served. Dietary manager visited with resident to explain how it works. Method of Correction for all residents A poster size substitute menu was posted in the main first floor dining room and smaller ones on table toppers which provides residents their options for alternatives. Staff to be educated on offering alternatives when resident are not eating their regular meal. Residents will be provided will alternate meal sheets to keep in their rooms for requesting other foods when they do not like the menu. This will be reviewed in resident council and with the family council. Dietary manager or designee will make random rounds in dining room at a minimum of two times per week including audit two times per week to residents who eat in their rooms to assure they are aware of the alternate foods available. QAPI and monitoring Dietary manager or designee will conduct	

random audits weekly until compliance is met then monitoring will be monthly to assure continued compliance in the dining rooms and in rooms where residents eat in their rooms. Audit will include resident name/date/ meal served/ if meal is being eaten/ were alternates offered/was resident aware. When residents state no alternates were offered, documented education is to be provided to the staff who assisted in meal service. Compliance threshold will be 80% and will be reported at regular QAPI meetings for need of further education or modifications. Dietary Manager to monitor.

Completion Date Staff educated on menu alternates **6/19/15**

Menu alternate sheets made available in resident rooms **7/14/15**

Alternate menu audits **7/14/15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 366	Continued From page 81 in bed, awake and alert. Continued observation revealed a meal tray sitting on the over bed table with a small portion of a biscuit and ham eaten and no other foods had been eaten. When Resident #2 was asked why he had not eaten, he stated "...don't like what they send..." Certified Nursing Aide (CNA) #1 was in the resident's room and stated "...he took a bite of the ham biscuit...said it was too hard...he don't have no teeth..." When CNA #1 was asked if any other foods had been offered, CNA #1 stated, "...no..."	F 366		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe outdoor smoking area for 1 of 1 designated resident outdoor smoking area. The findings included: Observation of the facility designated resident outdoor smoking area on 6/4/15 at 8:45 AM, revealed 2 residents seated in the paved area of the smoking courtyard, and 1 facility staff. Further observation revealed an uneven area of the pavement which was cracked and elevated above the rest of the pavement. Interview with the Activity Assistant, on 6/4/15 at 8:48 AM, in the outdoor smoking area stated the	F 465	F465 The facility will provide a safe environment for residents. Corrective Action Smoking Courtyard pavement was modified to provide safer access and smoking area was rearranged to avoid any further safety concerns. Method of correction for all residents All residents who smoke have been instructed on the revised smoking area and staff have been instructed to report any safety concerns from the modifications. QAPI and monitoring Activity Director will monitor weekly the outdoor smoking garden for any safety concerns and report immediately to Maintenance Director. Proper documentation of audit findings which include date/time/concerns viewed will be presented at regular QAPI meetings for any need of modification or concern. Compliance threshold is 100%.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 82 smoking area pavement had been cracked for "a while." Continued interview stated at one time there had been yellow caution tape used to block the raised section but it had been removed. Continued interview stated the raised area was a potential safety hazard to the residents. Continued interview revealed the residents were supervised by the staff when outside smoking. Interview with the Maintenance Supervisor, in the 1st floor Nursing Supervision office on 6/4/15 at 1:23 PM, stated the pavement in the smoking area was cracked when he became employed with the facility 7 months ago. Continued interview stated the uneven section of the pavement at one time had been taped off to prevent access. Interview with the Administrator on 6/4/15 at 2:20 PM, at the 1 West nurses station confirmed the pavement in the smoking area was a potential safety hazard. Continued interview confirmed the facility had failed to properly maintain the pavement in the smoking area.	F 465	Completion Date Smoking area modified **06/19/15** Activity Director audits begin **07/15/15**	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	F514 The facility will maintain clinical records on each resident that are accurately documented Corrective Action Staff providing care to residents #14 and 15 were counseled and educated on inaccurate documentation and falsification of records.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 83 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, review of the Bath/Shower Schedule, and review of the ADL (Activities of Daily Living) Flow Sheet Log, the facility failed to maintain accurate medical records for meal intakes for 2 (Resident #14, and 15) of 17 residents reviewed. The findings included: Medical record review revealed Resident #14 was admitted to the facility on 8/6/14 with diagnoses including Alzheimer's, Dementia with Behaviors, Gait Difficulties, Muscle Weakness and Depression. Review of the Quarterly Minimum Data Set (MDS) dated 2/15/15 documented the resident was severely cognitively impaired and required limited assistance from 1 person for eating. Observation on 6/8/15 at 8:35 AM in the resident's room revealed the resident was in the bed, her pureed breakfast tray was on the over the bed table in front of her. The resident's head was lying against the right upper side rail. Milk was spilled on the food and on the tray. The resident was patting the food with her hands. There was food and pepper on her gown, both hands, and forearms. The resident was alone, and no one was assisting her. CNA #5 entered the room at 8:48 AM and removed the uneaten breakfast tray.	F 514	F514 continued Method of Correction for all Residents All nursing personnel to be provided with education on falsification/ inaccurate documentation. Nurse Management or their designees will pull up Care Tracker audits on bathing and meal consumption weekly and compare documented information pulled from meal services and bath schedules. Inaccurate documentation will result in disciplinary action/education for employees. Audits of meal intake will be conducted randomly by Nursing Management or their designee at three different meals each week (one breakfast, one lunch and one dinner) to record actual meal intake of five different resident in the facility and compare to Care Tracker documentation. The audit will show resident name/date/ meal/Management recorded percent/Care Tracker recorded percent. Nurse Management will review for need of discipline/education of staff. Bath audits will be checked against recorded baths/showers given for accurate information. The audit will show resident name/date/ meal/Management verification of bathing/Care Tracker recorded bathing. Nurse Management will review for need of discipline/education of staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 84 Medical record review of the Meal Intake Detail Report dated 6/8/15 documented the resident consumed 50% of the breakfast meal, when in fact none was consumed. Interview with CNA #5 on 6/10/15 at 2:40 PM in the pharmacy room confirmed the resident did not eat any of the food on the breakfast tray on 6/8/15, and the documentation was not correct. Medical record review revealed Resident #15 was admitted to the facility on 6/14/13 with diagnoses including Dementia, Abnormal Posture, Hypertension, Oral Dysphagia, Hallucinations, Anxiety with Depression. Review of the Annual MDS dated 6/3/15 documented the resident had long and short term memory impairment, was totally dependent and required assistance from 1 person for bathing. Medical record review of the Bath/Shower Schedule dated 5/6/15 revealed Resident #15 was to receive a shower every Tuesday, Thursday and Saturday. Review of the ADL Flow Sheet Log dated 5/1/15 through 6/11/15 documented the resident received a shower 9 times during this time frame. Interview with CNA #10 on 6/10/15 at 2:40 PM in the pharmacy room confirmed the resident was not receiving showers as documented, as the shower room was too small to accommodate a shower stretcher, and the resident cannot tolerate sitting upright on the shower chair.	F 514	F514 continued QAPI and monitoring Nurse Management or designee will conduct audits and compile data for compliance. Compliance threshold will be 80% for bathing documentation and 80% for meal intake documentation and will be reported at regular QAPI meetings with need for education or modifications reported as well. Nurse Management to monitor. Completion Date Staff educated on documentation of accurate information **7/10/15** Audits of meal intake and bath documentation **07/16/15**	